REGIONAL PARTNERSHIP GRANT (RPG) PROGRAM: FINAL SYNTHESIS AND SUMMARY REPORT

OCTOBER 2013

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PROGRAM SUMMARY

President George W. Bush signed The Child and Family Services Improvement Act of 2006 (P.L. 109-288) into law on September 28, 2006 to improve the lives of abused and neglected children and their families. The Act was passed in response to parental substance abuse as a key factor underlying the abuse or neglect experienced by many children in the child welfare system. The law authorized and Congress appropriated $145 million over five years for a new competitive grant program entitled, "Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Use." Grants funded under this initiative-termed the Regional Partnership Grant (RPG) Program-supported states, tribes, and communities across the nation in developing regional partnerships "to provide, through interagency collaboration and integration of programs and services, services and activities that are designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children who are in an out-of-home placement or are at risk of being placed in an out-of-home placement as a result of a parent's or caretaker's methamphetamine or other substance abuse."

In October 2007, the Children's Bureau, in the Administration for Children and Families, Department of Health and Human Services awarded 53 Regional Partnership Grants (RPGs) to applicants across the country (See Appendix). The grant awards ranged from $500,000 to $1,000,000 per year. The legislation required the Secretary of the Department of Health and Human Services to submit annually a report to Congress on the services and activities provided by the grant, the performance indicators established under the grant, and the progress being made in addressing the needs of these families and in achieving the goals of child safety, permanence, and family stability.

The grants addressed a variety of common systemic and practice challenges that are barriers to optimal family outcomes. These challenges include recruitment, engagement, and retention of parents in substance abuse treatment; differences in professional perspectives and training; conflicting time frames across the systems to achieve outcomes; and chronic service shortages in both child welfare services and substance abuse treatment systems. Program strategies to address these barriers include the creation or expansion of family treatment drug courts, expanded and timely access to comprehensive family-centered treatment, in-home services, case management and case conferencing, the use of evidence-based practice approaches such as recovery coaches, mental health and trauma informed services, and strengthening of cross-system collaboration.

Data pertaining to twenty three performance indicators that address child welfare outcomes, substance abuse treatment outcomes, parent child relationships and family functioning, and regional partnership capacity were submitted twice yearly to the RPG web based reporting system. These performance indicators include child safety, permanency, and well-being; systems improvement; and treatment-related outcomes such as timeliness of treatment access, treatment completion, and parent's recovery.

The authorizing legislation required technical assistance to be provided to grantees. The Center for Children and Family Futures of Irvine, California, with partners including Planning and Learning Technologies (Pal-Tech) and ICF International were awarded the contract to support the grant program. Under this contract and in collaboration with CB, the team developed a

performance measurement and reporting system; conducted site visits with all 53 grantees and provided programmatic and evaluation-related technical assistance to grantees. At the same time, the RPG Program benefited from coordinated activities supported by the on-going intra-agency agreement between the Administration of Children and Families (ACF) and the Substance use and Mental Health Administration (SAMHSA) that jointly fund the National Center for Substance use and Child Welfare (NCSACW).

ACF used a performance monitoring approach to report on key performance measures according to data plans that matched their RPG program design and implementation context. The result is the largest data set about this population ever gathered in the United States, including information on more than 15,000 families comprised of more than 25,000 children and 17,000 adults.

Directly impacting the lives of more than 25,000 children, the RPG Program is the Federal government's largest single investment focused specifically on the lives of children and families at significantly high risk for negative outcomes related to substance use and child abuse or neglect.

The RPG Program has served some of America's most distressed families, and yet grantees were able to keep children at home at rates higher than national averages and safe with lower rates of repeated maltreatment. Furthermore, the changes in the families' lives associated with participation in the RPG Program were sustained beyond their involvement, including lower rates of re-removal even after leaving the program. Preliminary analyses of the dataset contributed by grantees suggest other important findings:

- The majority of children at risk of removal remained in their parent's custody. Most children in out-of-home placement achieved timely reunifications with their parent(s). After returning home, very few children re-entered foster care.
- Parents/caregivers achieved timely access to substance abuse treatment, stayed in treatment (on average, more than 90 days) and reported reduced substance use and gains in employment. They received essential clinical treatment and support services (e.g., continuing care, transportation, parenting training, mental health services, housing assistance) to promote and sustain their recovery and facilitate reunification.
- More than eight in every ten adults stayed in treatment for more than 30 days and 65.2 percent of adults in the RPG Program remained in treatment for more than 90 days.
- Single enrolled parent families in which the adult participated in substance abuse treatment included significantly fewer children than similar families in which the adult did not participate in treatment.
- Women are more successful in treatment regardless of their age or the number of children they parent.

- Substance abuse treatment participation and success are substantially enhanced by the use of recovery support coaches[1] even when compared to much more expensive alternatives such as intensive case management.
- Family Drug Courts are among the most powerful innovations in terms of linking adults with substance abuse treatment, keeping them engaged in treatment, and seeing them through to successful completion.
- Successful sustainability required early and substantial discussions among collaborative partners, technical assistance (TA) to use evaluation, and other information to identify sustainable components and make the case for sustainability to decision-makers and engagement with key stakeholders. Nearly three-fourths of the major services and activities provided through the RPG Program will be sustained after the grant.

Over the course of the RPG program, grantees learned that sustainable, expanded capacity to serve these families required more than a narrowly defined, grant-funded project. Those grantees who were most successful in terms of sustaining the collaborative policies and practices necessary to meet the families' complex needs addressed issues related to sharing costs, following clients from referral through service receipt, engaging leadership across agencies and using performance monitoring, and local evaluation information to inform decision-making seriously.

Finally, those grantees who took on the challenging task of estimating the long-term impact of investing in services for whole families affected by substance abuse and involved in child welfare found potential for significant savings. These savings varied by cost study methodology and location, but were substantial nonetheless. For example, one grantee estimated more than $6 million in savings of out-of-home care costs during the grant period.[3]

The RPG Program represents the broadest Federal program ever launched to assist states, tribes, and communities across the nation to improve the well-being, permanency, and safety outcomes of children who are in, or at-risk of out-of-home placement as a result of a parent's or caregiver's methamphetamine or other substance abuse. This report is a summary and synthesis of the accomplishments and lessons learned from the first cohort (FY2007-2012) of RPG Program grantees. Information contained in this report is derived from reviews of grantee Semi-Annual Progress Reports, performance indicator data submitted to the RPG data collection system, grantee Final Progress Reports, program monitoring by Federal Project officers, and technical assistance and evaluation activities provided by Children and Family Futures. The information in this report is responsive to the requirements in the authorizing legislation by addressing:

1. The services and activities conducted under the RPG Program;
2. The set of performance indicators established to track the progress of the RPG Program; and
3. The progress that has been made in addressing the needs of families with methamphetamine or other substance abuse problems who come to the attention of the child welfare system and in achieving the goals of child safety, permanence, and family stability.

[1] Recovery support coaches serve in a non-clinical role, often in conjunction with formal treatment or mutual aid groups, to initiate or maintain recovery from drug or alcohol abuse.

The report exceeds those requirements by presenting additional information about how grantees increased their organizational capacity to serve children and families and sustained their program after federal funding ended. The report concludes with recommendations and suggestions for program development, as well as future evaluation and research. Finally, HHS hopes that this report will inform collaborative policy and practice across the nation to improve outcomes for children and families in the child welfare system who are affected by substance use disorders.

Appended to the end of the main body of this document are site summaries of the 44 grantees that have completed RPG-funded work and submitted Final Reports. Site Summaries are based on various sources including: Grantee Semi-Annual Progress Reports, Grantee Final Reports, Semi-Annual Data Uploads, and Performance Management Liaison (PML) reviews.

BACKGROUND

Over 8.3 million children in the United States under the age of 18 live with a parent who is dependent on alcohol or need treatment for a substance use disorder, representing 11.9 percent of children nationwide.[4] This rate increases to 14 percent for children under the age of five.[5] Parental substance use and co-occurring risk factors can place the family at an increased threat of child maltreatment (particularly neglect) and trauma, often stemming from maladaptive parenting practices and chaotic home environments. A recent study found that 61percent of infants and 41 percent of older children in out-of-home care had a caregiver who reported active alcohol or drug abuse.[6]

Approximately three children in a typical elementary school classroom are living in a home with parents who are abusing drugs or alcohol.

Substance use among parents can impact multiple domains of parenting practices and family functioning. Substance use can influence the parents' behavior directly, as the mind- and mood-altering effects of alcohol and drug use may inhibit the parent's capacity for consistent and sensitive parenting.[7] Substance-abusing parents are more likely to: 1) use inconsistent, irritable, explosive or inflexible discipline; 2) offer low supervision and involvement in the family; 3) provide insufficient nurturance and inconsistent emotional responses to children; and, 4) be tolerant of youth substance use.[8,9,10] These maladaptive parenting styles may put the children and family at risk of disrupted parent-child attachment and family well-being. Substance use also alters the home environment—homes with substance abusing parents are often chaotic and unpredictable. Poor parenting practices and a chaotic home environment combine to put children at increased risk of physical or emotional abandonment, abuse and neglect.[11] If this cycle is uninterrupted by effective intervention, it may lead to multi-generational trauma and abuse.

The cognitive and neurodevelopmental deficits stemming from exposure to parental substance use may also trigger child behavioral and social-emotional problems.[12] For example, perinatal drug exposure has been found to adversely impact social-emotional interactions between infants and their mothers, which may lead to difficulty in sustaining attention and behaviorally self-regulating emotion, which may have long-term negative impacts on child development.[13,14] The inability to self-regulate diminishes children's capacity to respond to stressful environments. The combination of the neurodevelopmental deficits due to perinatal exposure to drugs and

alcohol and contact with a traumatic and unpredictable environment can put children and youth at great risk for their own mental health and substance use disorders in adolescence and early adulthood.[15]

Finally, parental substance use and child abuse or neglect is strongly associated with trauma that can further burden children and families. Research has shown that women with substance use problems have a 30 percent to 59 percent rate of dual diagnosis involving post-traumatic stress disorder (PTSD) and substance use, frequently stemming from a history of childhood physical and/or sexual assault.[16] Of a treatment-seeking sample of substance users, 60 percent to 90 percent also had a history of victimization.[17] Failure to understand and address parent trauma may lead to: 1) the failure of parents to engage in substance use treatment services; 2) an increase in symptoms; 3) an increase in management problems; 4) re-traumatization; 5) an increase in relapse; 6) withdrawal from the service relationship; and, 7) poor treatment outcomes.[18]

Children exposed to substance use in the home are five times more likely to have experienced a traumatic event and have a stress response to that event than children who were not exposed to a caregiver's substance use.[19] The Adverse Childhood Experience (ACE) Study indicated that living in a household with parental substance use is associated with trauma and future health and mental health problems.[20] For example, children raised in households with alcohol-abusing caretakers were found to be at significantly greater risk of experiencing all nine of the other adverse experiences than those who did not grow up in such households.[21] Traumatic events experienced early in life, such as exposure to family violence and physical abuse, which are more likely with substance abusing parents, can lead to a greater risk of developing PTSD and substance use.[22]

For all of these reasons, well-being will increase substantially among a majority of families involved with child welfare if systems meaningfully address parental substance use issues.[23] It is crucial to address the factors that affect the lives of children and families as a result of parental substance use, and the key is to provide an effective treatment program that addresses the needs of both the parents and the child to ensure that the well-being of all family members is protected.

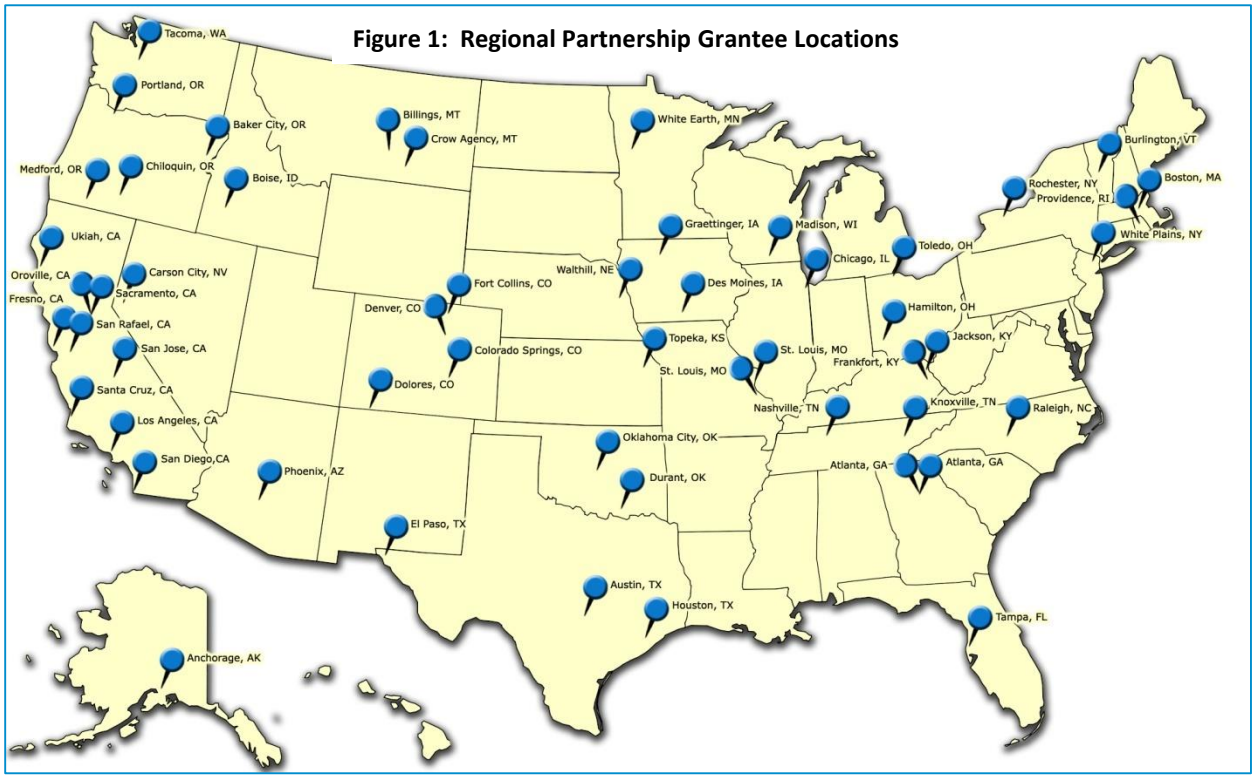
It is within these complex, multidimensional challenges that the RPG programs implemented their projects. The report addresses a series of key questions including:

- Who participated in services and activities provided by grantees?
- What services and activities were conducted under the RPG Program?
- What were the results from the set of performance indicators established to track the progress of the RPG Program?
- What progress was made in addressing the needs of families and in achieving the goals of child safety, permanency, and well-being?
- How did grantees perform in improving regional collaboration and expanding capacity?
- How did grantees sustain their programs after federal funding ended?

RPG PROGRAM OVERVIEW

The lead agencies for the 53 Cohort 1 RPG Grantees were based in 29 states and included six tribes or tribally affiliated agencies (see Figure 1 below and Appendix).

Figure 1: Regional Partnership Grantee Locations



"Regional partnerships" are defined as two partners, one of which must be the State child welfare agency. Tribes are exempted from this requirement, but must include at least one non-Tribal partner.

Cohort 1 RPG programs served residents of 180 counties. Approximately one-third (28 percent) of these counties are 75 percent or more rural. Three grantees focused on a single city and two grantees implemented services statewide. A wide range of governmental and private sector organizations representing child welfare, substance use treatment, the courts and other child and family services functioned as lead agencies for the RPG projects. Furthermore, the overall regional partnership composition is broad for all grantees and extends beyond the two-partner minimum requirement specified in the legislation (see Table 1).[24]

Table 1: Breadth of the Regional Partnerships and Their Interagency Relationships
• All 53 regional partnerships included representatives from child welfare services and substance use treatment agencies and organizations • 81.1 percent of the partnerships included family drug courts (FDCs), adult drug courts, other collaborative courts or court-related agencies • 75.5 percent of partnerships included mental health agencies or providers • 73.6 percent included other community-based organizations that provide child and family services • 66.0 percent involved criminal justice and legal systems partners • 60.4 percent involved child and/or adult health services agencies or providers • 52.8 percent included partners from education or early childhood education • 43.4 percent included State or local employment agencies or employment/vocational service providers • 37.7 percent included housing agencies or services providers

TARGET POPULATION

Grantees targeted services to families with children who have been removed from home and placed in out-of-home care and those who are at risk of removal, but are still in the custody of their parent or caregiver (i.e., in-home cases). Within these groups, some grantees emphasized a specific subpopulation, such as pregnant and parenting women, parents and their young children (0 to 5 years), substance-exposed newborns, or families involved with the criminal justice system. More than one-third of grantees served voluntary child welfare cases, pre-filing cases, or differential or alternative response[2] cases in which participants enter or exit the grantee's program voluntarily and do not have open family court cases.[25]

Nearly all grantees included interventions to address the effect of methamphetamine use on child welfare involvement. However, most grantees did not limit their focus to methamphetamine, given the predominance of polysubstance use among most clients and drug use patterns that are unique to each part of the country. Further, during the last few years, several grantees have noted an increase in the number of clients they are seeing who are abusing prescription-type drugs, which is consistent with the recent national trends.[26]

[2] Alternative response is a practice in response to cases of reported child abuse or neglect and is usually applied in low- and moderate-risk cases. It generally involves assessing the family's strengths and needs and offering services to meet the family's needs and support positive parenting. Although a formal determination or substantiation of child abuse or neglect may be made in some cases, it is typically not required.

SERVICES AND ACTIVITIES

The grant announcement to which RPG applicants responded specified that grant funds could be used in five program areas:

- Systems collaboration and improvements
- Substance use treatment linkages and services
- Services for children and youth
- Clinical and community support services for children, parents and families
- Capacity expansion to provide treatment and services to families

All grantees carried out their programs in unique environmental contexts that informed the selection of interventions and the strategies by which those interventions were implemented. Grantees' program activities are summarized in Table 2.[27]

Table 2: Grantees' Program Activities
Systems Collaboration and Improvements
• 100 percent of grantees conducted cross-systems training on clinical as well as program and policy issues • 98 percent convened regular regional partnership meetings to discuss programmatic issues and collaborative management and administration • 94 percent held regular joint case staffing meetings to discuss families' case plans or other treatment issues • 93percent implemented improvements in cross-systems information sharing and data collection • 87 percent developed formalized cross-systems policies and procedures to improve communication, identification, referrals and service delivery • 62 percent co-located staff to assist with screening, assessment, referral and/or provision of services • 59 percent used a formal multidisciplinary team decision-making process (e.g., Family Group Decision Making)

Table 2: Grantees' Program Activities (continued)
Substance Use and Mental Health Treatment Services and Linkages for Parents and Caregivers
• 96 percent of grantees implemented specialized outreach, engagement and retention services • 93 percent screened or assessed for substance use disorders • 87 percent provided intensive coordinated case management • 81 percent implemented trauma-informed or trauma-specific services • 78 percent implemented family-based substance use treatment services • 74 percent conducted specialized screening or assessments to identify other needed services (e.g., trauma) • 73 percent provided outpatient services • 72 percent engaged in one or more substance use prevention activities • 64 percent provided mental health services or psychiatric care • 39 percent provided residential treatment • 34 percent developed a new FDC or expanded or enhanced an existing FDC
Services for Children and Youth
• 93 percent of grantees screened and assessed for child welfare issues • 76 percent conducted specialized screenings and assessments (e.g., developmental, behavioral) • 53 percent provided early intervention and/or developmental services • 45 percent provided therapeutic services and interventions • 35 percent screened or assessed children for trauma issues • 34 percent implemented trauma services for children • 19 percent provided remedial or academic supports to school-age children • 6 percent provided substance use treatment for youth who have a substance use disorder • 87 percent of grantees provided some type of parenting training, education or program • 68 percent provided wraparound and/or individual in-home services • 64 percent provided aftercare, continuing care and recovery support services • 64 percent provided housing services • 57 percent provided family therapy or counseling • 37 percent provided supervised, supportive or therapeutic supervised visitation services • 34 percent conducted targeted outreach and engagement of fathers and/or provide a specialized program or services for fathers

Table 2: Grantees' Program Activities (continued)
Expanded Capacity to Provide Treatment and Services to Families
• 81 percent of services and activities that grantees have implemented have strengthened their collective regions' capacity to serve families by creating new services or expanding and/or enhancing existing services that increased the number of families served or improved the quality and delivery of existing services (e.g., provided a more intensive or higher level of service, changed type and level of staff) • 33 percent created completely new services created for the RPG target populations • 49 percent represented an expansion and/or enhancement of an existing service

Grantees noted that in order to meet the needs of families, they often had to change program interventions or approaches as these needs were often emerging quickly. As one grantee noted, "our whole focus kind of changed when we got involved with the drug court and we were able to do that so [because the FPO] really gave us flexibility to listen to our partners and then provided the services and fill the gaps. We wouldn't have been nearly as successful if we hadn't have been able to do that." The grantee also noted that the flexibility allowed them to change to a different program curriculum, which proved to be very successful for the population served. Another grantee also noted that their initial plan to provide short-term case management changed to meet the needs of the partners. Instead of providing short-term case management, they implemented a mentoring component to the substance abuse treatment providers, which included technical assistance and mentoring. "I think the fact that we implemented the mentoring component of our project [has allowed us to be] more family focused."

One grantee noted the need to be flexible in order to meet the needs of mothers with infants entering the program. For example, the grantee noted that the treatment center "really had a hard time figuring out what to do with the babies and how to integrate babies into treatment with moms…[For example,] the babies were a distraction…moms were going to appointments, [trying] breastfeed and wanting to carry their babies [all at the same time]." The grantee was able to respond to the emerging needs of the infants and mothers and consider more appropriate, sensitive approaches.

Cultural-specific Strategies for Native American Families

As noted above, grantee lead agencies included six tribes. In tribal communities, client engagement and retention often represents a significant challenge. Many evidence-based practices do not address the broad cultural, historical, and intergenerational traumas that Native Americans have experienced. Nor have most interventions been evaluated in Native communities. In light of these challenges, the six tribal grantees were able to address the need for more culturally responsive interventions. Specifically, they adapted practice-based and evidence-based engagement and treatment strategies to more effectively serve native families by:

- Increasing family access and connection to local traditional cultural supports
- Incorporating prayer in group activities

- Educating parents on how tribal-specific historical and contemporary trauma impacts traditional tribal parenting approaches
- Using the tribal language
- Conducting culture-based ceremonial approaches to celebrate family or individual successes
- Examining cultural expectations of gender-based roles and responsibilities for both adolescents and adults

In addition to the above overarching approaches, tribal grantees implemented several specific practice- and evidence-based culturally adapted program strategies for their communities (highlighted below). The grantees reported these efforts were effective in overcoming long-standing engagement and retention barriers for native families and facilitating positive outcomes.

- Four of the six tribal grantees used the Positive Indian Parenting program to help parents regain a connection with their culture. The curriculum blends the strengths of historic Indian child-rearing patterns and values with modern skills.[3]
- One grantee used Honoring Children, Mending the Circle (HC-MC), which is a cultural adaptation of evidence-based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents. HC-MC guides the therapeutic process through a combination of American Indian and Alaska Native traditional teachings and cognitive-behavioral methods. This grantee also provided Project Making Medicine,[4] a clinical training program based on the Honoring Children, Mending the Circle curriculum.
- One grantee implemented the evidence-based Wellbriety treatment model[5] with culturally-based recovery support groups and other cultural support services including equine therapy. The grantee used their data to demonstrate to the counties, who provided the majority of substance abuse treatment services, that tribal programs can address tribal members' outpatient treatment needs effectively. The tribe is now able to provide a full continuum of services that are reimbursable by the state, a major policy and service delivery change. One grantee that focused on providing substance abuse treatment to the tribal youth used the Walking in Beauty on the Red Road (WBRR) curriculum. WBRR is a holistic cultural residential treatment model for American Indian and Alaska Native youth and their families. The model weaves indigenous cultural beliefs and teachings with westernized evidence-based approaches while providing therapeutic treatment services.[6]

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[3] More information on the Positive Indian Parenting program is available from the National Indian Child Welfare Association (www.nicwa.org), which developed the curriculum.

[4] Project Making Medicine is for mental health professionals from tribal, urban, Indian Health Service, and residential treatment agencies who provide child abuse prevention and treatment.

[5] Wellbriety is a culturally- and community-based model that incorporates the teachings of the Native American Medicine Wheel and 12 Step Traditions as well as Native traditional healing practices into treatment programs.

[6] Sabin, C., Benally, H., Bennett, S. & Jones, E (n.d.). *Walking In Beauty on the Red Road: A Holistic Cultural Treatment Model for American Indian and Alaska Native Adolescents and Families.* Chestnut Health Systems. Retrieved July 24, 2013 from http://www.chestnut.org/Portals/14/PDF_Documents/Lighthouse/Manuals/Shiprock-Walking_In_Beauty_on_the_Red_Road.pdf.

- Two grantees developed and implemented a cultural assessment tool to identify families' spiritual, mental, emotional, and physical needs and inform treatment planning. The grantees reported the cultural assessment process strengthened client engagement and retention and ensured client's received appropriate level of care. In one site, several of the tribal social services programs now use the tool.

The tribal grantees' experiences and insights emphasized the pivotal role that culture plays in addressing the treatment needs of high-risk Native families involved in the child welfare system. Over the course of the grant, these six partnerships implemented various interventions that began to address systematically their communities' need for culturally appropriate interventions. The tribal grantees reported that collectively, these interventions helped address families' inherent distrust and fear of participating in services, strengthened engagement and retention, and improved clients' commitment to sober and healthy lifestyles. Continued evaluation of these approaches in tribal communities is needed to further establish the efficacy of these cultural strategies in improving outcomes with the tribal child welfare population.

Resources Targeted to Key Services That Address Children's, Parents' and Families' Needs

Interviews with grantee leadership revealed a number of suggestions about the distribution of resources toward key activities based on lessons they learned through the RPG Program.

Visitation

Grantees identified increased visitation as an important component for their program. One site noted that staff time was dedicated to advocating for increased visitation. "We started developing a more focused approach and taking a significant stand [to advocate] on behalf of families, [especially] children, around the fact that one hour every two weeks [is] not a visitation. That is not how you maintain a parent-child bond. There needs to be significant attention paid to that." Another grantee noticed that increased visitation also demonstrated a shift in perception about the parents. For example, "people saying, 'get those kids away from those abusing parents.' That [perception has] changed." As a result, this site is now offering three or four days of visitation a week to strengthen and nurture the parent-child bonds.

Connecting Related Services for the Whole Family

Grantees realized that they would need to shift the resources to meet the needs of the children entering programs with their parents. For example, they noted that while they had been referring children and families for mental health treatment, they needed to make a solid connection to the service providers. Once established, these connections were able to improve the partnership.

Parenting Skills

Grantees noted that the RPG had led them to consider the importance of more recent findings about the value of parenting for improving outcomes for children and parents affected by substance use. One site observed that the RPG project allowed for the consideration of parenting programs based on what was being "developed and tested in laboratories with more information about the needs of children." Specifically, the grantee noted that newer programs "talk about

what happens to children when separated [from their parents] and where there's a focus on bonding and attachment and a gaining of an understanding of [how] that attachment leads to [success] in any other relationship." Another grantee shared, "[we are] really drilling down into parent-child bonding and attachment in a way we've never looked at before." For instance, family-focused services, such as having a parent educator on staff and nursing services, helped to address the child(ren)'s he and medical needs."

Support for the Whole Family

Grantees realized that the best outcomes were achieved when the whole family system received support. For example, one grantee noted that they found it important to provide services to foster parents if a child was in out-of-home care. The grantee would have to consider the question of, "how are we helping the foster parents to understand the substance abuse disorder, so they can help that child, [instead of] approaching this family with a fear?" This grantee worked to engage foster parents and to develop relationships with them that would support the mother and child. Another grantee was able to link other children in the household to needed services. As they stated, "when you look at child welfare, there's a single child that they're focusing on…They wouldn't necessarily look at the needs of another child [in that family so] that other child wouldn't get services, even though they need them." Through case management services, this grantee was able to connect children throughout the entire county to needed services. Another grantee recognized this issue as well. The drug court which they began to work with was only serving the drug court participants, but "the family was left out of this, the children were left out [and] the spouse was left out." They were able to work with a local partner to bring those services in for the families, and with the RPG "created a more cohesive treatment plan for the whole family."

One of the tribal grantees emphasized the value of family-based service delivery in enhancing client engagement. This partnership instituted monthly elder potlatches (luncheons), where elders share historic stories with families to promote the identification of cultural values. To further build the trust critical to family engagement, this grantee is using Native Family Services Workers, who represent the service area's many different tribes.

WHO PARTICIPATED IN RPG PROGRAMS?

Grantees served complex, high-risk populations including significant numbers of children who had a history of maltreatment along with their parents who were often the perpetrators of abuse and neglect. Parents were also very likely to be unemployed and relied on government agencies and other social service organizations for housing, food and other essentials. Together with substance abuse, mental illness, and frequent involvement with judicial systems, these family characteristics reflected the challenging populations served by the RPG program.

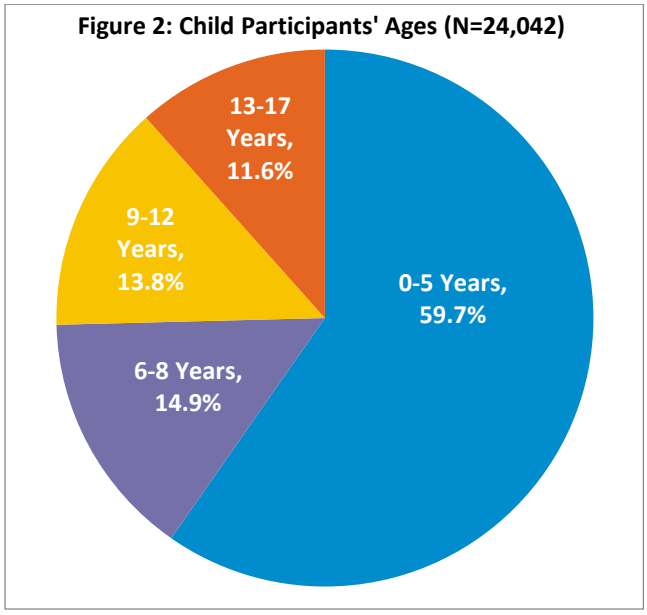
Over the course of their five-year grant period, the 53 Cohort 1 RPGs served 15,031 families including 25,541 children and 17,820 adults. The number of adults in each family unit ranges from one to 14; however, families in which one or two parents are enrolled in the RPG Program comprise 98.0 percent of all family units included in the following analyses. Collectively,

families with one parent enrolled in RPG[7] include an average of 1.86 children. Family groups with two parents enrolled in RPG include an average of 2.23 children.

The average number of RPG participant families served per grantee was 284, ranging from a low of 62 to a high of 1,886. This broad range reflected the diversity of the 53 grantee program models, the size of geographic regions grantees served and differences in client populations.

Many children had a history of abuse and neglect. Slightly more than one-third (34.5 percent) of children had a history of maltreatment that was not associated with their current RPG program enrollment. Families with a history of child welfare system involvement that pre-dates their RPG participation adds to the complexity of their needs and, according to grantees, can make client engagement more challenging.

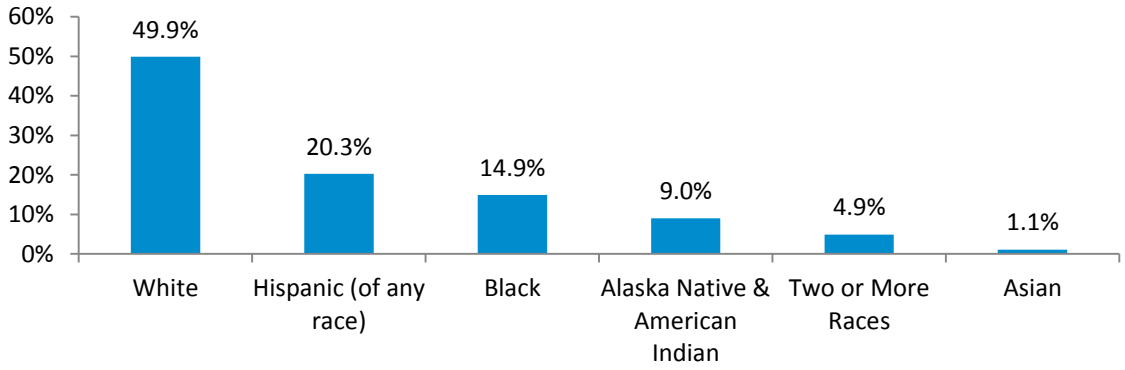
Grantees served approximately equal numbers of girls and boys who were, on average, 5.7 years of age when they entered RPG program services. Over half (59.7 percent) were ages 0 to 5 years. One-fifth (20.5 percent) were infants less than one year old; approximately one-fourth (26.1 percent) were one to three years old and 13.1 percent were four to five years old. Among school-age children, 14.9 percent were ages six to eight years old, 13.8 percent were nine to twelve years old and the remaining 11.6 percent were thirteen years or older (Figure 2). Tribal grantees, in particular, tended to serve a greater percentage of older children than other grantees. For instance, 46.5 percent of the children served by the Tribal grantees were nine years or older, compared to 23.7 percent for all other grantees.



[7] Of the 9,045 single parent participant families enrolled in RPG, the parent is male in 14.4% of the cases and female in 85.6%. Marital status data were reported for 75.8% of these parents 4,902 (59.7%) were "never married" and 1,163 (17.0%) were "now married." The families in both groups include between 1 and 9 children, with a mean of 1.80 children among "now married" parents and 2.07 children among those "never married." "Single enrolled parent families" in the RPG Program are not necessarily single parent families, defined as only the mother or the father receiving no physical assistance from the other parent to raise one or more dependent children.

As Figure 3 shows, children in the RPG Program were predominantly White (49.9 percent). Approximately one-fifth (20.3 percent) were Hispanic, while 14.9 percent were Black and 9 percent were Alaska Native/American Indian. A very small percentage of children served were multiracial (4.9 percent) or Asian (1.1 percent).[28]

Figure 3: RPG Children, Percentage by Child's Race/Ethnicity (N=22,469*)



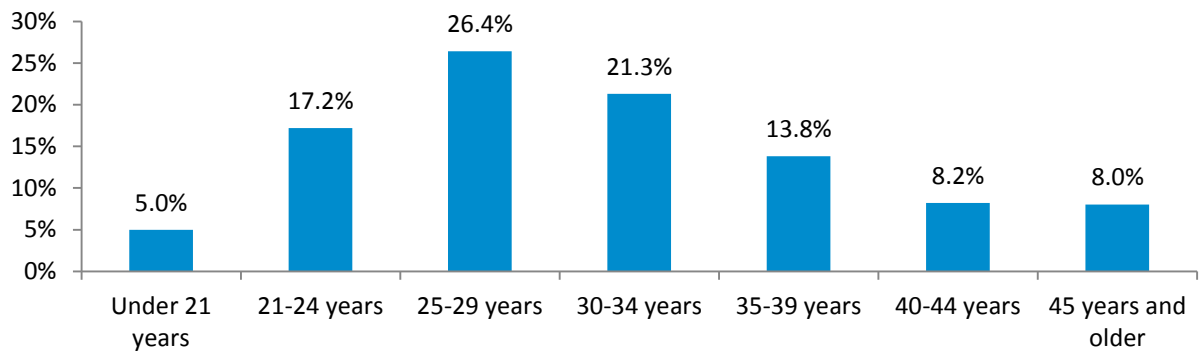
*All races exclude children of Hispanic origin; Asian includes Native Hawaiian/Other Pacific Islander. Excludes children with missing data on race/ethnicity.

RPGs served very high risk and high need adults. More than one-third (36.5 percent) of all adults were prior perpetrators of child maltreatment and had a history of past child welfare system involvement (not associated with their current RPG Program participation). Further, adult RPG participants were likely to be unemployed and receiving public assistance at the time of program enrollment; in fact, 12 grantees served an adult population that was 70 percent or more unemployed. This profile echoes the traumatic cycle suffered by families at the intersection of substance abuse and child welfare.

In general, adult RPG participants tended to be White females in their late 20s or early 30s who have never been married and are the biological mother and primary caregiver of the child(ren) receiving services. Nearly one-fourth (24.3 percent) of all adults served were married at time of RPG enrollment. Nearly three-fourths (72.2 percent) of adult RPG participants were females.

The mean age among adults at the time of RPG enrollment was 31.4 years. Nearly half of all adults were 25 to 34 years old. As Figure 4 shows, a small percentage (5 percent) were under 21 years of age, while 17.2 percent were 21 to 24 years old. The largest proportion of adults was 25 to 29 years (26.4 percent), followed by 30 to 34 year olds (21.3 percent). Those 35 to 39 years old comprised of 13.8 percent of all adults. A roughly equal percentage of adults were 40 to 44 years old (8.2 percent) or 45 years and older (8 percent).

Figure 4: RPG Adults, Percentage by Age Group (N=17,388*)



* Excludes adults with missing data.

Limitations in Interpreting the Data

These data provided an unprecedented opportunity to assess the impact of the RPG programs on child welfare and substance abuse outcomes. Yet several important caveats must be considered in reviewing data that represent 53 partnerships with different program models and diverse target populations:

The RPG Program Performance Measurement is not designed as a cross-site evaluation. The RPG findings presented in this report represent 53 grantees that have the same overarching project goals (to improve child, adult, and family outcomes), but are not implementing or testing the same set of services, interventions, or program models.

Grantees implemented different methodologies for obtaining control or comparison group data, if applicable to their project. Grantees were not specifically required to include a control or comparison group in their local evaluation design. Grantees collecting control or comparison group data had the discretion to identify and select what they deemed an appropriate control or comparison group.

Contextual and community factors may impact grantees' outcomes. The 53 regional partnerships operated within broader communities and systems of care. As such, the partnerships, programs, and families served were impacted by local conditions including the service array available in different communities and the current economic environment. State and county budget constraints and recent reductions impacted the grantees in important ways.

National child welfare and substance abuse treatment outcomes provide important contextual perspective, but may reflect a broader child and adult population than the RPG families. Families served by the RPG programs likely represented more difficult or complex cases (e.g., significant co-occurring disorders, including trauma and violence). Further, the state contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants, as these data do not reflect random assignment or matched characteristics of RPG participants.

In summary, RPG grantees focused their efforts on very high need families facing significant challenges related to poverty and low education in addition to substance use and child maltreatment. These characteristics are important contextual considerations for the performance information that follows in the next section because families reached by grantees are more difficult to engage and serve than those involved with either substance abuse or child welfare systems alone.

HOW DID GRANTEES PERFORM IN MEETING FAMILIES' NEEDS?

The summary of the grantees' performance begins with an overview of the information related to safety, permanency, and well-being before moving to a discussion about adult recovery.

SAFETY, PERMANENCY AND WELL-BEING

Grantees exceeded national standards or other contextual comparisons[29] and steadily improved performance by keeping children safe and at home and by improving child and family well-being throughout program implementation. The majority of children at risk of removal remained in their parent's custody. Most children in out-of-home placement achieved timely reunifications with their parent(s). After returning home, very few children re-entered foster care. Furthermore, parents and caregivers achieved timely access to substance abuse treatment, stayed in treatment (on average, more than 90 days) and reported reduced substance use and gains in employment. They received essential clinical treatment and support services (e.g., continuing care, transportation, parenting training, mental health services, housing assistance) to promote and sustain their recovery and facilitate reunification.

Overall child, adult, and family well-being improved from program admission to discharge (for the subset of grantees who measured and reported child well-being). However, the grantees' experiences in measuring well-being reflected a field in development and the inherent challenges associated with assessing change in such complex constructs. Their efforts, perhaps best viewed as an important and ongoing learning process, provided several important insights for strengthening future measurement of this critical outcome area.

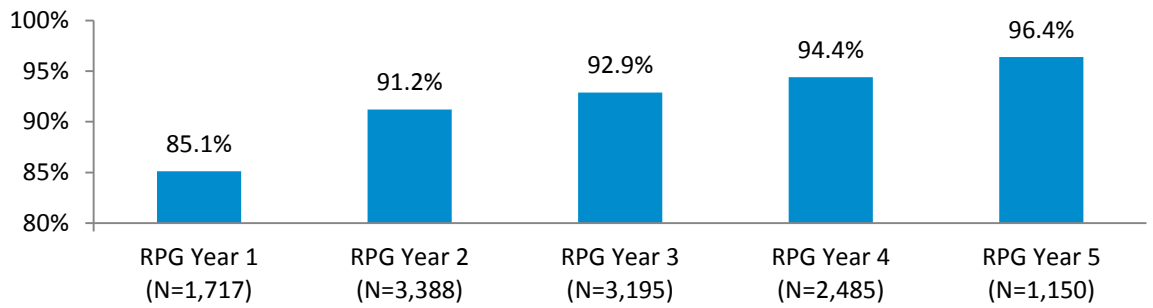
Safety

Keeping children safe and at home prevents family disruption and trauma that is associated with removal. Practices such as removal from home, multiple placements in out-of-home settings, transfers to new schools and separation from existing social support networks, may exacerbate effects of trauma(s) from abuse and neglect (Cook et al., 2005 and Ko et al., 2008). Additionally, systems able to keep families together realize savings associated with out-of-home placements. More than 90 percent of children remained at home throughout their participation in the RPG Program and they do not appear to have been exposed to greater risk of repeated maltreatment (the rationale used for removal). This is an important marker of the grantees' ability to ensure the safety of children participating in RPG activities and presents potential savings associated with out-of-home placements.

Within the first six months following RPG Program enrollment, 95.8 percent of participating children did not experience maltreatment, exceeding the national standard by 1.2 percent. Furthermore, grantees improved their performance in these areas throughout program

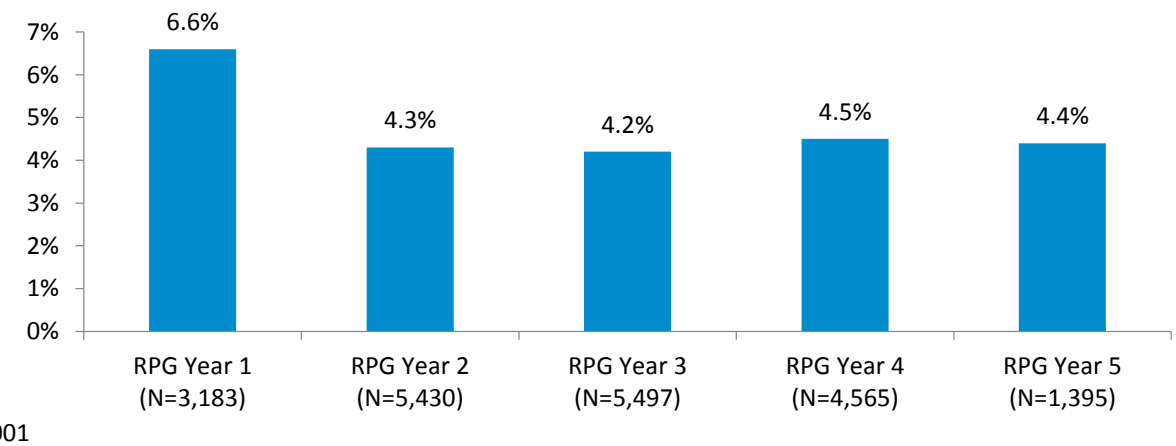
implementation as illustrated in Figures 5 and 6. Specifically, the proportion of children who remained in-home through RPG case closure increased steadily over the course of the RPG Program (see Figure 5). It increased from 85.1 percent in program year one (N=1,717) to 91.2 percent in year two (N=3,388) to 92.9 percent in year three (N=3,195). Performance continued to improve during the latter part of the grant period, increasing from 94.4 percent in program year four (N=2,485) to 96.4 percent in the final program year (N=1,150).

Figure 5: Percentage of Children Who Remained at Home, by RPG Program Year



Children participating in RPG programs suffered maltreatment (unrelated to the maltreatment that led to their RPG participation) less frequently over time. In other words, there was a steep decline followed by stability after the first year of implementation (Figure 6). Specifically, the rate went from 6.6 percent in program year one to 4.3 percent in program year two, and declined further to 4.2 percent in program year three, 4.5 percent in year four and 4.4 percent in program year five.

Figure 6: Percentage of RPG Children Experiencing Child Maltreatment within 6 Months of RPG Program Enrollment, by RPG Program Year



p<.001

The RPGs' overall average fell well below the rates of maltreatment among the 25 states in which the grantees were situated (Table 3)

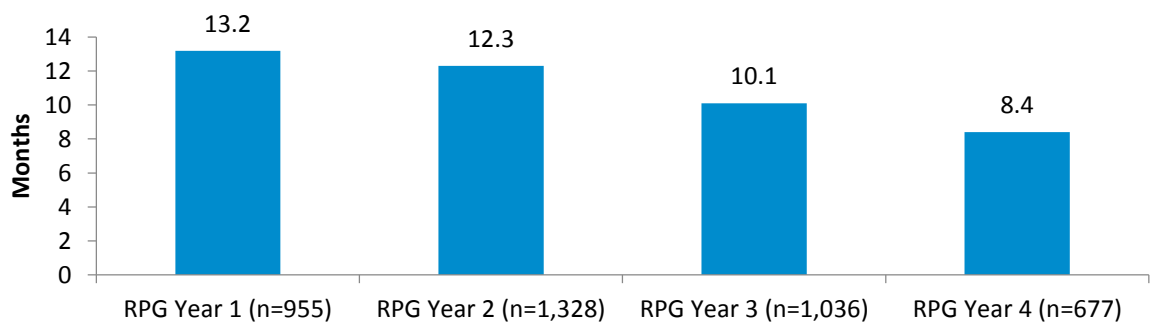
Table 3: Substantiated/Indicated Child Maltreatment Within 6 Months After RPG Program Enrollment (Median Performance)		
	Children in the RPG Program (N=22,558)	**25-State Contextual Subgroup Data[30]**
Percentage of Children Who Had Substantiated/ Indicated Maltreatment Within 6 Months After RPG Program Enrollment	4.2%	5.8%
Notes: RPG data represents 44 grantees reporting case-level maltreatment data; analysis excludes 1,620 cases missing data elements needed to calculate time of maltreatment in relation to RPG program entry. The state contextual subgroup data are the 2011 NCANDS median results for the 25 States in which the 44 RPG programs are located (the lower the percentage, the better). The state contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants.		

Permanency

Unfortunately, sometimes removing the child from their home is unavoidable and while family preservation is an important goal, many factors may lead to child removal. In some cases, child welfare workers may recognize that the risk of repeated maltreatment is too high. In other situations, the parent(s) may indicate that they are unable or unwilling to provide care. Also, family residential treatment may not be available for those parents requiring such services. When a child is removed and separated from his family due to unsafe or unfit conditions, the primary goal becomes decreased stay in foster care and timely permanency either through reunification or alternative placement.

For those families participating in RPG programs with children removed from their homes, the median length of stay in foster care decreased steadily over the course of the RPG Program, from a median of 13.2 months in year one to 8.4 months in program year four (see Figure 7).

Figure 7: Among Children in RPG Discharged from Foster Care During the RPG Program, Median Length of Stay in Foster Care in Number of Months, by Program Year



Among children reunified, the median length of stay in foster care was 9.5 months. This was two months longer than the state contextual subgroup median of 7.5 months (see Table 4).

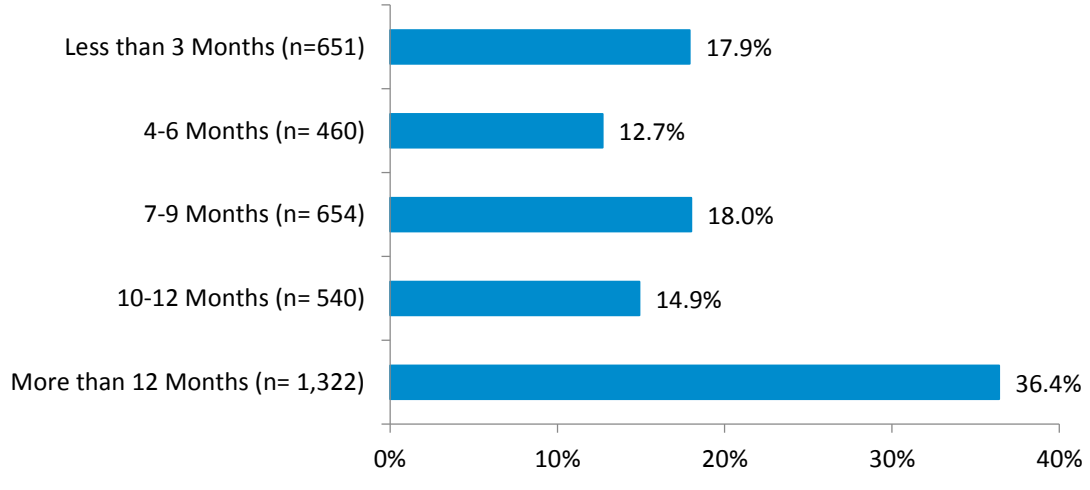
Table 4: Length of Stay for Children Discharged from Foster Care – Median Number of Months

	RPG Program Data	State Contextual Data[31]
Discharge to Reunification (n=3,340)	9.5 months	7.5 months
Discharge to Finalized Adoption (n=418)	24.2 months	29.3 months

Notes: RPG data represents 34 RPGs that reported any formal foster care discharges at this time (all reasons); only 22 of the 34 RPGs reported any discharges to finalized adoption. Analysis excludes an additional 169 RPG children discharged from foster care due to missing data elements needed to calculate length of stay in foster care. The State Contextual Subgroup Data for discharge to reunification are the 2011 AFCARS results for the 22 States in which the 34 RPG programs are operating; the State contextual data for discharges to adoption reflect the 16 States in which the 22 RPGs that had any finalized adoptions are operating. The State contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants. See *Analysis, Interpretation, and Clarification* Issues for contextual State performance measure operational definitions for discharge to reunification and discharge to finalized adoption.

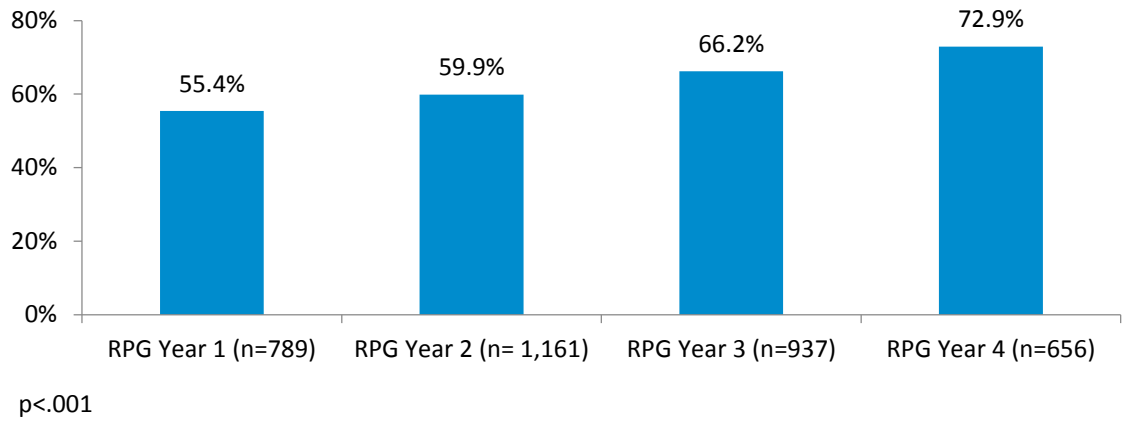
When children are removed from their home, it is important to reunify them with their parents as soon as it is safe to do so. Timely reunification may reduce the number of disruptions to the child and therefore, reduce associated trauma and other risk factors. Overall, nearly two-thirds (63.6 percent) of children were reunified in less than 12 months. More specifically, 17.9 percent of children were reunified in less than three months, 12.7 percent were reunified in four to six months, 18 percent within seven to nine months and 14.9 percent in ten to twelve months. More than one-third (36.4 percent) were reunified in more than twelve months (Figure 8).

Figure 8: Percentage of RPG Children Reunified within Specified Intervals (N=3,627)



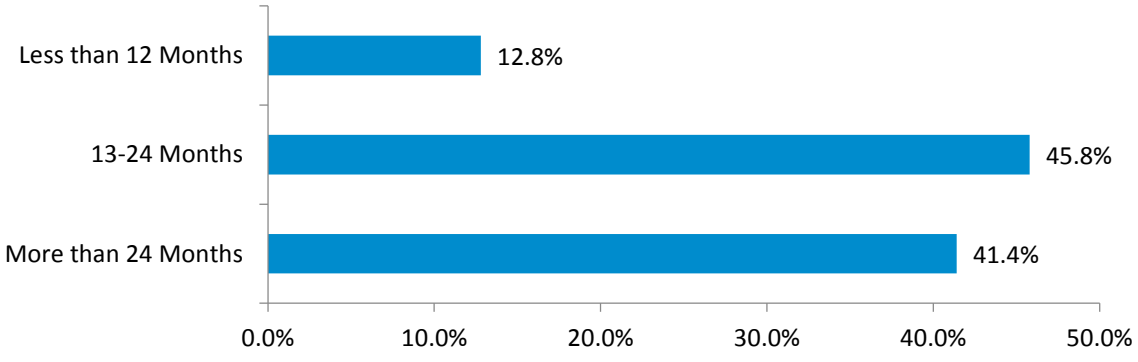
The percentage of children in the RPG Program reunified within 12 months (69.8 percent) is consistent with the contextual 22-State subgroup median of 69 percent. Furthermore, timeliness of reunification (i.e., within 12 months) has improved steadily and significantly over the course of the RPG Program, from 55.4 percent in program year one to 72.9 percent in program year four (see Figure 9).

Figure 9: Percentage of Children Reunified Within 12 Months, by Program Year



Sometimes reunification goals cannot be achieved and it is in the children's best interest to find an alternative permanent placement. This can include adoption or assignment of legal guardianship to another caregiver. To date, 452 children who were in foster care have been discharged to a finalized adoption or legal guardianship, accounting for 11.8 percent of all RPG foster care discharges. Achieving permanency quickly helps reduce the disruption and trauma to the child so grantees sought to make sure that children found a permanent home in as short a period of time as possible. More than half (58.6 percent) of children in the RPG Program exiting foster care into adoption or guardianship did so within 24 months (see Figure 10).

Figure 10: Percentage of Children Discharged to Adoption or Relative Guardianship Within Specified Intervals (N=452)



Of the children participating in RPG programs discharged to adoption, 50.3 percent achieved a finalized adoption within 24 months. This exceeded the median of 33.7 percent for the 15 States

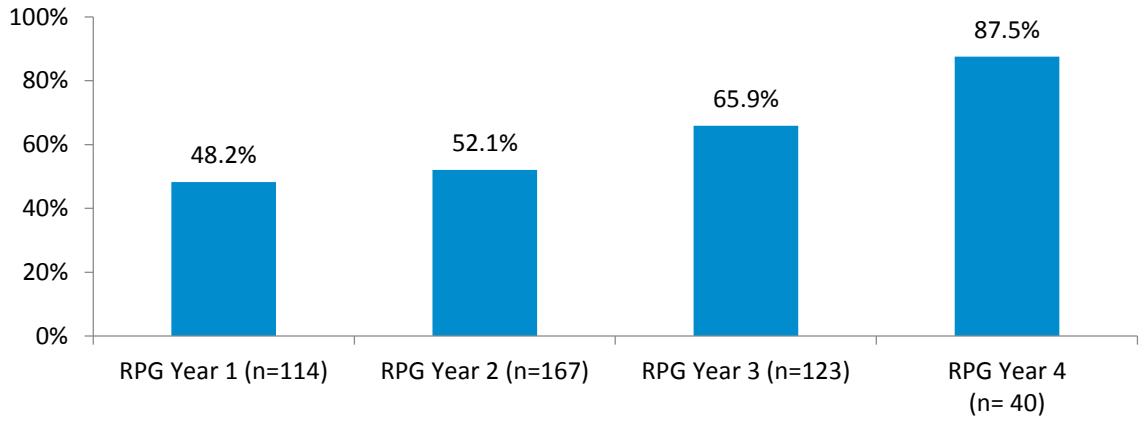
in which the RPGs who reported any adoptions are operating (see Table 5). More than three quarters (80.2 percent) of those discharged to legal guardianship did so within 24 months.

Table 5: Children Who Achieved a Finalized Adoption Within 24 Months (Median Performance)		
	RPG Program Data (N=164)	**15-State Contextual Subgroup Data[32]**
Percentage of Children Who Exited to a Finalized Adoption in Less than 24 Months	50.3%	33.7%

Notes: RPG data represents 18 RPGs that have reported any finalized adoptions to date; analysis excludes an additional 14 cases due to missing data elements needed to calculate time to adoption. The State Contextual Subgroup Data are the 2010 NCANDS results for the 15 States in which these 18 RPG programs are operating. The State contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants. Contextual State Data performance measure operational definition: Of all children discharged from foster care to a finalized adoption during given fiscal year, percentage who were discharged in less than 24 months from the date of the latest removal until date of discharge.

The percentage of children with removal dates before program exit achieving timeliness of permanency (within 24 months) has increased over time (see Figure 11).[33]

Figure 11: Percentage of Children with Dates of Removal Preceding RPG Program Exit Achieving Finalized Adoption or Guardianship in Less than 24 Months, by RPG Program Year*

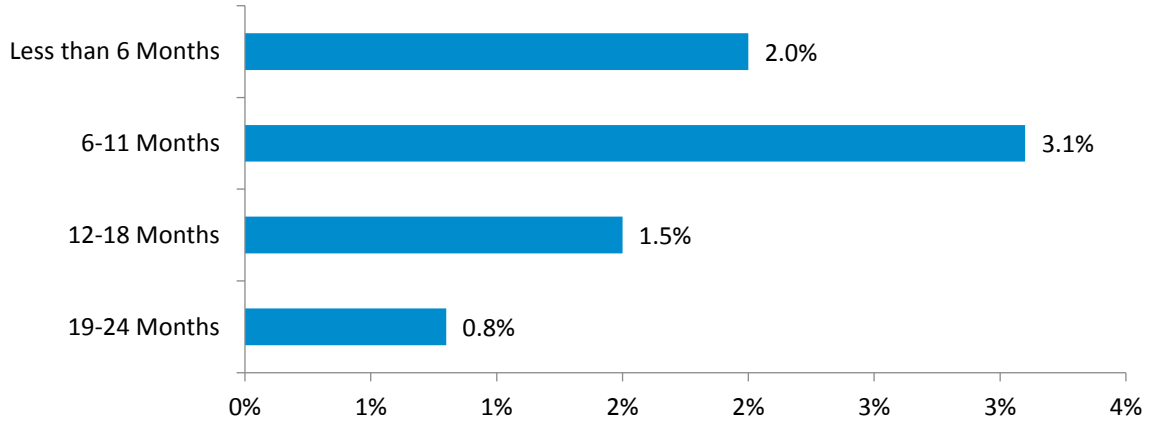


* Data for program year five are excluded due to small sample size.

Timeliness to permanent placement and a reduction of time in foster care must be balanced with concerns about recurrence of maltreatment. Therefore, RPG projects also tracked whether children of families who participated in RPG programs re-entered the foster care system after being returned to their parents.

More than half of the grantees reported that none of their reunified children re-entered foster care. Among children reunified, only 283 (7.3 percent) re-entered foster care at any point within 24 months following reunification. Most of those who re-entered did so within six to eleven months of being reunified (see Figure 12).

Figure 12: Percentage of Children who Re-Entered Foster Care after Reunification, Within Specified Intervals (N=283)



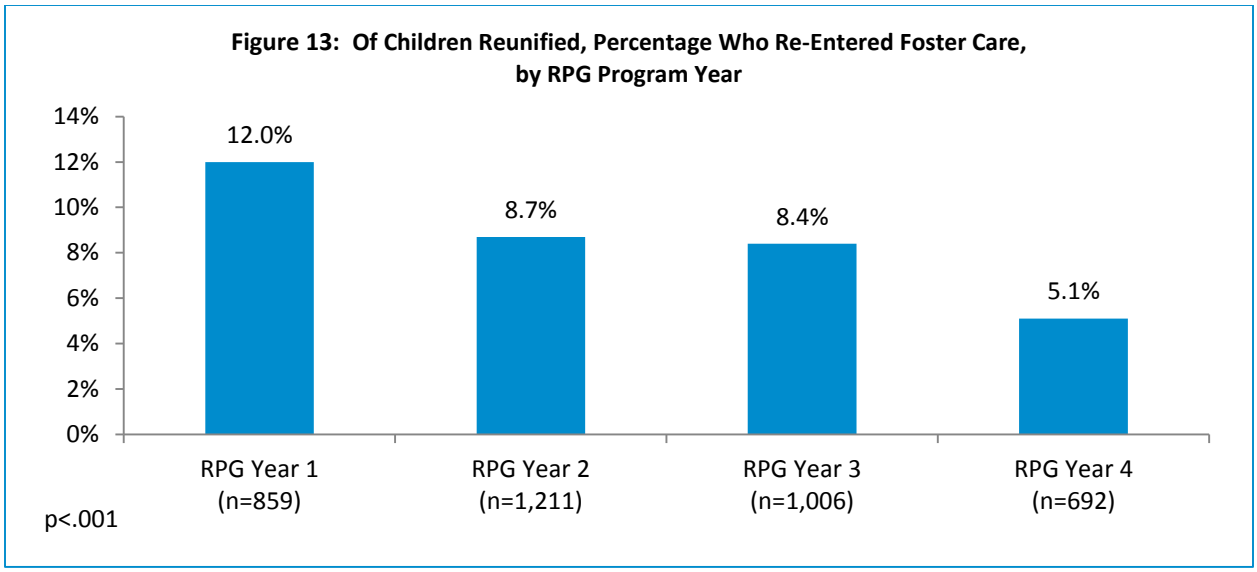
The percentage of RPG children who re-entered foster care within 12 months (5.1 percent) was substantially lower than the median rate of 13.1 percent for the 22 States in which the RPGs are operating (see Table 6).

Table 6: Children Reunified Who Re-entered Foster Care in Less than 12 Months (Median Performance)

	Children Served by the RPG Program (N=3,575)	22-State Contextual Subgroup Data[34]
Percentage of Children Reunified Who Re-entered Foster Care in Less than 12 Months	5.1%	13.1%

Notes: RPG data represents 36 RPGs and are limited to the 3,575 reunified children for whom timeliness of reunification data were available. The State Contextual Subgroup Data are the 2011 AFCARS results for the 22 States in which the 36 RPG programs are operating (the lower the percentage, the better). The State contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants. Contextual State Data performance measure operational definition: Of all children discharged from foster care to reunification in the 12 month period prior to given fiscal year, percentage who re-entered foster care in less than 12 months.

Furthermore, the percentage of children who re-entered foster care has decreased steadily over the course of the RPG Program from 12 percent in year one to 5.1 percent in year four (see Figure 13).



Child and Adult Well-being

Regardless of child placement, RPG programs also sought to address the well-being needs of children and their families. When the RPG Program was implemented in September 2007, the Children's Bureau's Child and Family Service Review (CFSR) process defined well-being as parent capacity to care for the health and educational needs of their children. Over the past several years, measurement of well-being has evolved and become more clearly defined.[35,36] This section begins with a summary of well-being findings that reflect the evolution of measurement and then discuses findings related to indicators established at the outset of the RPG program.

Grantees measured child well-being, adult mental health, parenting capacity, family relationships and functioning and risk and protective factors using instruments they identified as appropriate for their specific program model and target population. HHS did not require grantees to use specific clinical instruments or the same instruments to measure the well-being indicators. Therefore, specific data elements vary across grantees with all grantees collecting data regarding at least one well-being indicator. Although these inconsistencies make conclusions more difficult to draw, they do point to potentially important findings summarized in Table 7.

Table 7: Highlights of Child, Adult and Family Well-Being Findings
Child Well-Being*
At RPG Program Entry: • 33.8 percent of young children ages 0 to 5 years old were identified in need of further assessment or monitoring in at least one domain of physical development • 31.0 percent of young children ages 0 to 5 years old were identified in need of further assessment or monitoring in at least one domain of cognitive development • Between 19.6 percent and 22.4 percent of young children ages 0 to 5 years old were identified as having or at risk of social, emotional or behavioral difficulties • 49.1 percent of school-age children (ages 6 to 18 years old) were identified in the clinical or borderline range for behavioral issues **During RPG Program Participation:** • Majority of children and youth received needed supportive services that included substance abuse prevention and education (91.1 percent), primary pediatric care (85.3 percent), educational services (82.3 percent), mental health or counseling services (80.0 percent), developmental services (75.0 percent) and substance abuse treatment (69.2 percent) **From RPG Program Entry to Discharge:** • Percentage of children for whom overall child well-being was rated a strength significantly increased from 24.8 percent to 53.0 percent
Adult Well-Being*
At RPG Program Entry: • 37.2 percent of adults exhibited mild to severe depressive symptoms **From RPG Program Entry to Discharge, Parents or Caregivers:** • Reported a significant decrease in total parental stress • Showed reductions in levels of unemployment, alcohol and drug use, legal issues, medical issues, family conflict and psychiatric symptoms • Showed statistically significant improvements in their overall parental capabilities; by program discharge, this area was rated a strength for approximately half (46.5 percent) of parents, up from 14.9 percent at program admission

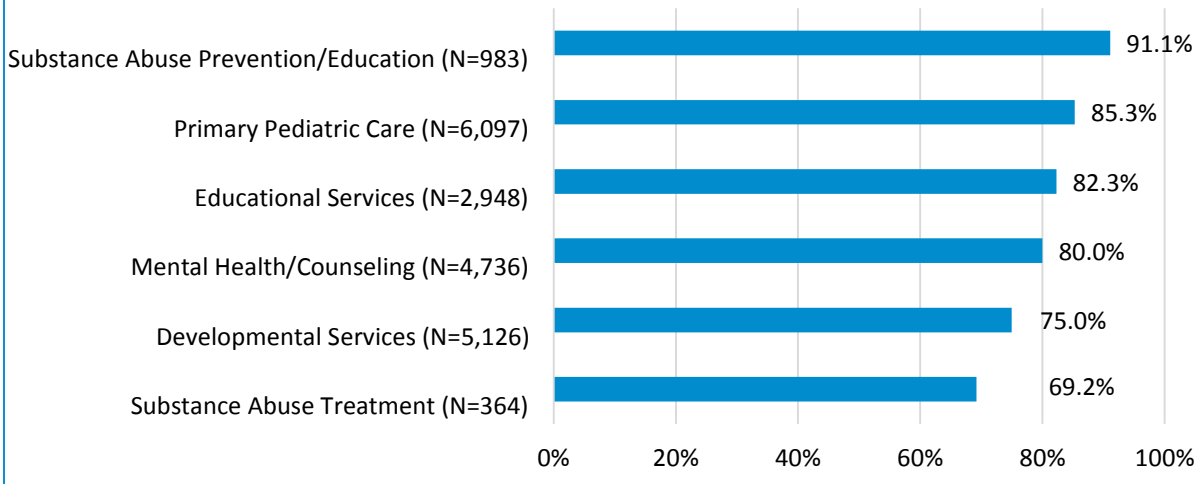
Table 7: Highlights of Child, Adult and Family Well-Being Findings (continued)
Family Well-Being*
At RPG Program entry: • Nurturing and attachment between a parent and child was seen as families' greatest strength area • Concrete support to help families cope with stress was the area in need of the most improvement **From RPG program admission to discharge, families:** • Showed statistically significant improvements in their overall family interactions, environment and family safety – At program admission, the percentage of families with a strength rating in these areas ranged from approximately one-fifth to one-fourth; by program discharge, this had increased 41.0 percent to 47.0 percent (depending on the area)
* Baseline data represent the subset of grantees using the ASQ, ASQ-SE and CBCL; baseline to discharge data reflect the subset of grantees using the NCFAS (Overall Child Well-Being subscale item). ** Baseline data represent the subset of grantees using the Beck Depression Inventory and full PSI; baseline to discharge data reflect the subset of grantees using the NCFAS (Overall Parental Capabilities subscale), the PSI – Short Form, the ASI and the AAPI-2. *** Baseline data represent the subset of grantees using the Protective Factors Survey; baseline to discharge data reflect the subset of grantees using the NCFAS (Overall Family Interactions subscale, Overall Environment subscale and Overall Family Safety subscale).

Children Connected to Services

The majority of children received assessments to identify key supportive service needs. Seventy-five percent or more were assessed regarding primary pediatric care, substance abuse prevention, educational services, mental health or counseling services and developmental services while more than two-thirds (69.2 percent) were assessed for substance abuse treatment.

The majority of those children assessed and identified as needing a given supportive service were connected to such services. As Figure 14 shows, between 80 percent and 91.1 percent of children received mental health or counseling, educational services, primary pediatric care and substance abuse prevention or education. Three-fourths (75 percent) of children received developmental services and more than two-thirds (69.2 percent) received substance abuse treatment, as needed.[37]

Figure 14: Percentage of RPG Children Who Received Selected Supportive Services (Of Those Assessed and for Whom a Given Service Was Identified as a Need)



Note: Substance abuse prevention/education services applies to children ages 5 and older; substance abuse treatment applies to children ages 12 and older.

Adults Connected to Services

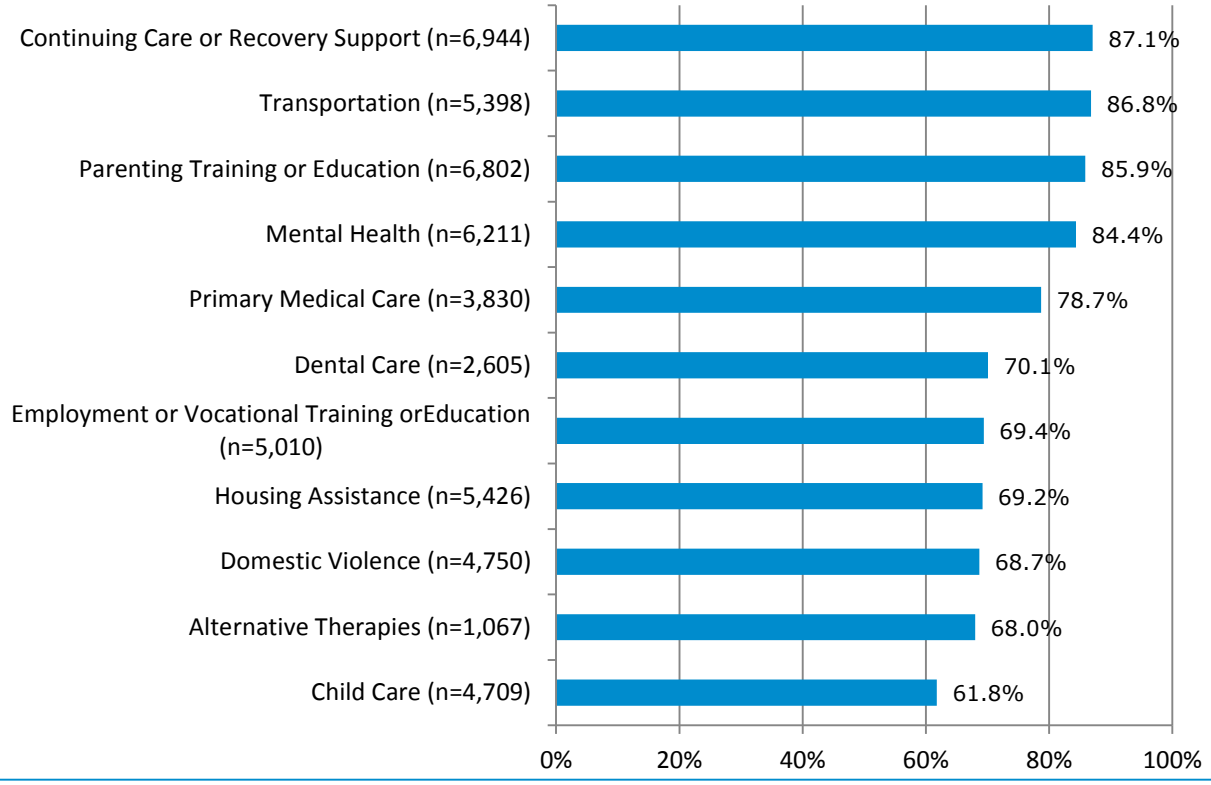
As suggested previously, RPG grantees implemented a wide range of substance abuse treatment strategies including combinations of prevention activities, non-intensive and intensive outpatient treatment, short-term, long-term and specialized parental residential treatment, partial hospitalization, and aftercare. Most grantees also provided a range of parental support strategies that may have included intensive case management (ICM), peer or parent mentors and/or recovery coaches to facilitate participation in treatment. Some grantees expanded, enhanced or implemented new FDCs. In these settings, substance abuse treatment was typically mandatory.

RPG programs assessed adults for the following needs: 1) continuing care (87.1 percent); 2) transportation (86.8 percent); 3) parenting training/education (85.9 percent); 4) mental health (84.4 percent); 5) primary medical care (78.7 percent); 6) dental care (70.1 percent); 7) employment or vocational training or education (69.4 percent); 8) housing assistance (69.2 percent); 9) domestic violence (68.7 percent); 10) alternative therapies (68.0 percent); and, 11) child care (61.8 percent).

Figure 15 illustrates the finding that between 61.8 percent and 87.1 percent of adults assessed as in need of a given service actually received it. More than eight out of every ten adults assessed for and identified as in need of continuing care and recovery support services (87.1 percent) received these services. Among all other services, the proportions receiving the service of the number assessed and found in need are: 1) continuing care (87.1 percent); 2) transportation (86.8 percent); 3) parenting training/education (85.9 percent); or, 4) mental health (84.4 percent). Further, approximately six out of every ten adults or more assessed for and identified as in need of the following services received: 1) primary medical care (78.7 percent); 2) dental care (70.1 percent); 3) employment or vocational training or education (69.4 percent); 4) housing assistance

(69.2 percent); 5) domestic violence (68.7 percent); 6) alternative therapies (68.0 percent); or, 7) child care (61.8 percent).

Figure 15: Percentage of RPG Adults Who Received Selected Supportive Services (Of Those Assessed and For Whom a Given Service Was Identified as a Need)

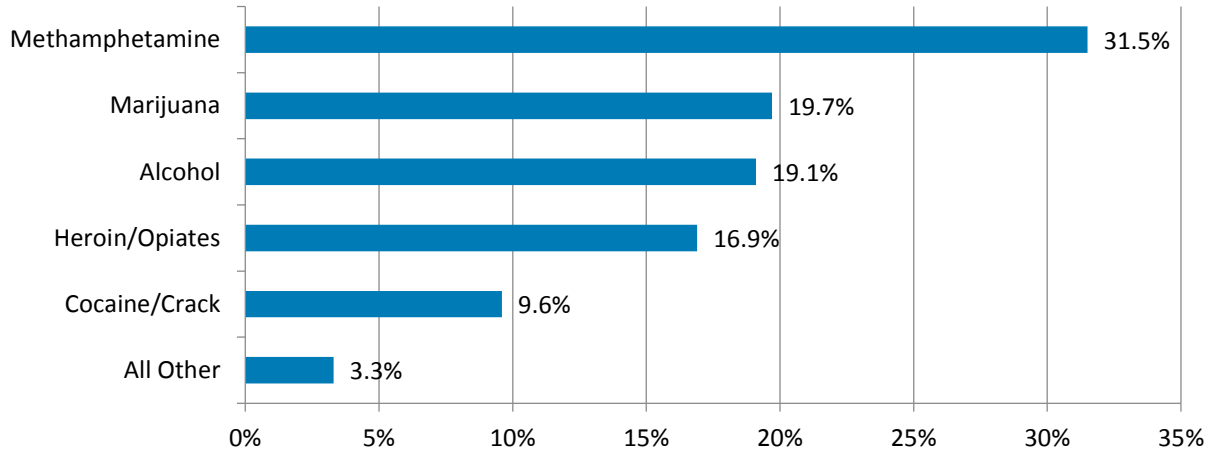


Corresponding to this diverse array of program strategies, the proportion of adults who participated in substance abuse treatment varied considerably across grantees. The percentage of adults that participated in one or more episodes of substance abuse treatment after entering the RPG Program ranged from 7 percent to 100 percent, with a median of 65.1 percent. Finally, there was a much higher proportion (74.1 percent) of adults in the RPG Program who participated in substance abuse treatment after program entry than the corresponding proportion of adults referred for substance abuse treatment but who were not enrolled in RPG (47.1 percent).

ADULT RECOVERY

Adult recovery is key to positive outcomes for families and often disrupts the traumatic cycle of abuse and neglect of children. Therefore, grantees assessed adults for their substance use at program exit and each time they entered treatment during RPG participation. Considering just the first treatment episode, nearly one-third (31.5 percent) of the adults in the RPG Program were admitted for treatment for methamphetamine[38] as the primary substance problem, followed by marijuana (19.7 percent), alcohol (19.1 percent), heroin/opiates (16.9 percent) and cocaine/crack (9.6 percent). The remaining 3.3 percent of adults admitted for treatment the first time presented some other drug[39] as the primary problem (see Figure 16).

Figure 16: Primary Substance Problem at First Treatment Admission among Adults in the RPG Program (N=10,004)



Note: Other includes hallucinogens, benzodiazepines, barbiturates, other tranquilizers and sedatives and other drugs. Calculation of percentages excludes 1,116 cases missing primary substance data.

A much larger proportion (31.5 percent) of adults in the RPG Program reported methamphetamine as their primary drug problem at treatment admission than the combined adult treatment population in the states in which their RPG programs are located. Just 7.1 percent of the treatment admissions for the states in which the reporting RPG programs were located[40] indicated methamphetamine or other stimulants as the primary problem. Conversely, alcohol accounted for 40 percent of the States' overall admissions compared to 19.1 percent of first treatment episodes among adults in the RPG Program. The percentage of states' admissions for heroin or other opiates (23 percent) was higher than that among adults in the RPG Program (16.9 percent), while states' admissions for marijuana (18.3 percent) were slightly lower than among adults in the RPG Program (16.9 percent). Similarly, states' admissions for cocaine (7.8 percent) were lower than for first admissions to substance abuse treatment among adults in RPG (9.6 percent).[41]

Data indicated that substances abused by adults in the RPG Program frequently included some combination of methamphetamine, marijuana, and alcohol. Further evidence of this particular combination was found by analyzing the primary and secondary drug problem identified at first treatment admission. Considering just adults with two episodes of substance abuse treatment, 54.9 percent are accounted for by linkages between methamphetamine, marijuana, and alcohol as primary and secondary drug problems at first treatment admission.

Given these rates of substance use and the complexity of treating polysubstance users, grantees made significant efforts to improve the participants' recovery. Grantees' performance in terms of adult recovery included measures of:

- Timely access to substance abuse treatment
- Retention in substance abuse treatment
- Reduction in substance use

- Employment status
- Decrease in criminal behavior

Timely Access to Treatment

As suggested previously, RPG grantees implemented a wide range of substance abuse treatment strategies including combinations of prevention activities, non-intensive and intensive outpatient treatment, short-term, long-term and specialized parental residential treatment, partial hospitalization, and aftercare. Most grantees also provided a range of parental support strategies that may have included intensive case management (ICM), peer or parent mentors and/or recovery coaches to facilitate participation in treatment. Some grantees expanded, enhanced or implemented new FDCs. In these settings, substance abuse treatment was typically mandatory.

Overall, adults participating in the RPG Program accessed substance abuse treatment quickly, on average, within 13 days of entering the RPG program. Well over one-third (36.4 percent) entered substance abuse treatment within 3 days.

Corresponding to the diverse array of program strategies, the proportion of adults who participated in substance abuse treatment varied considerably across grantees. The percentage of adults that participated in one or more episodes of substance abuse treatment after entering the RPG Program ranged from 7 percent to 100 percent, with a median of 65.1 percent participation in treatment.

Cumulatively, families in which one or two parents are enrolled in the RPG Program comprise 98 percent of all family units included in analyses of participation in substance abuse treatment. Single enrolled parent families in which the adult participated in one episode of substance abuse treatment after RPG entry included significantly fewer children (an average of 1.78 children) than similar families in which the adult did not participate in treatment (an average of two children). Similarly, two parent families in which one or both adults participated in treatment (averages between 1.92 and 2.42 children, depending upon the parental pattern of participation in treatment) included significantly fewer children than similar families in which neither parent participated in substance abuse treatment (an average of 2.64 children).

Families in which the adult participated in substance abuse treatment included significantly fewer children than similar families where the adult did not participate in treatment.

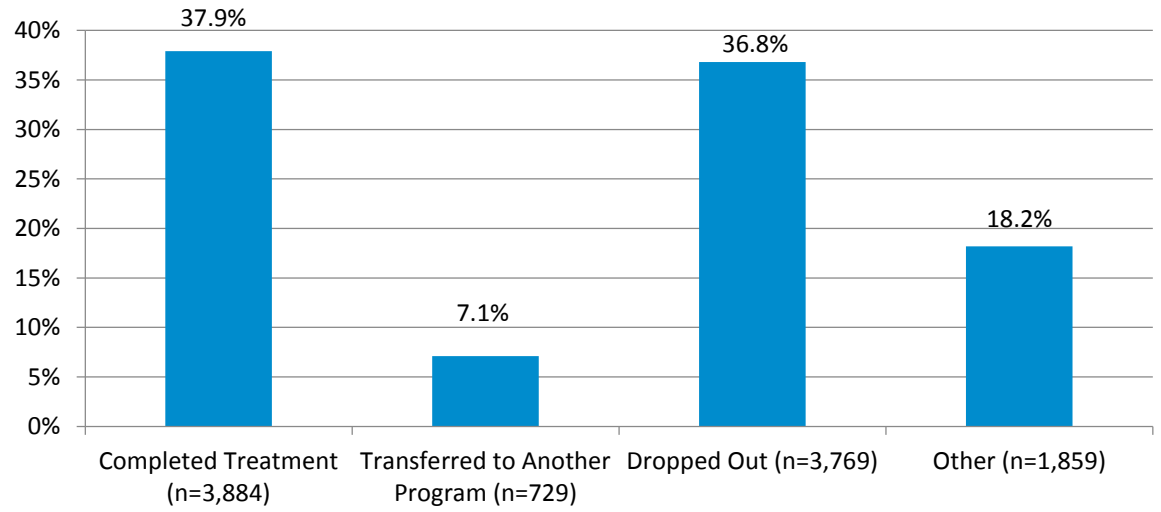
Parent gender in single parent enrolled families is significantly associated with the length of stay in substance abuse treatment and with positive treatment outcomes. Considering treatment completion and "transfer for further treatment and known to report" (considered a positive treatment outcome per Federal treatment episode reporting), the rate of successful treatment outcomes for single parent enrolled families in the RPG Program with a male parent is 42.9 percent, compared to 52.4 percent in single parent enrolled families with a female parent.

The median length of stay in treatment across all discharge categories is longer (148 days) in single parent enrolled families with a female parent than in similar families with a male parent (128 days).

Retention in Substance Abuse Treatment

Considering the 10,241 discharges from substance abuse treatment among adults in the RPG Program with valid discharge data, 37.9 percent were recorded as "completed treatment," 7.1 percent of these discharges were transfers to another program or facility for further treatment (considered a positive treatment outcome per Federal treatment episode reporting) and 36.8 percent of discharges indicated that the adult dropped out of treatment (Figure 17).[42]

Figure 17: Substance Abuse Treatment Discharges, Percentage by Discharge Status (N=10,241)



Adults in the RPG Program had a median length of stay in substance abuse treatment of 146 days (4.8 months).[43] More than eight out of every 10 adults (84.8 percent) stayed in treatment more than 30 days and 65.2 percent of adults in the RPG Program remained in treatment more than 90 days. This is important as the National Institute on Drug Abuse states the threshold for significant improvement is reached at about three months in treatment.

Intensive Case Management alone is the most frequently implemented parent support strategy; however, it is associated with the lowest rate of participation in substance abuse treatment.

Retention in substance abuse treatment was also related to the strategy or strategies implemented by grantees. Parent support strategies were analyzed in relation to adult participation in substance abuse treatment *after* RPG Program entry. As depicted in Table 8, there were significant differences between parent support strategy combinations and the extent of participation in substance abuse treatment; X^2 (10, N=12,504) = 1,709.044, $p < .001$.

Table 8: Participation in Substance Abuse Treatment After RPG Program Entry by Parent Support Strategies				
Parental Support Strategy Combination (n= the number of grantees implementing the strategy)	**Episodes of Substance Abuse Treatment**			
	None Percent (*n*)	**1 Episode Percent (*n*)**	**2 or More Episodes Percent (*n*)**	**Total Percent (*n*)**
Intensive Case Management Only (27)	37.4% (2,985)	50.6% (4,040)	12.1% (964)	100.0% (7,989)
Intensive Case Management and Recovery Coaches (7)	24.4% (219)	67.1% (602)	8.5% (76)	100.0% (897)
Intensive Case Management and Peer/ Parent Mentors (9)	15.6% (176)	54.6% (616)	29.8% (336)	100.0% (1,128)
All Three Parent Support Strategies (3)	11.3% (126)	65.1% (723)	23.6% (262)	100.0% (1,111)
Recovery Coaches Only (1)	8.0% (46)	92.0% (529)	0.0% (0)	100.0% (575)
No Parent Support Strategy (3)	0.1% (1)	99.9% (803)	0.0% (0)	100.0% (804)

The highest substance abuse treatment participation and retention rate is associated with the implementation of a "Recovery Coaches Only" strategy. All 575 adults exposed to this parental support strategy were served by one grantee,[44] which limits the extent to which this finding can be generalized.

Recovery coaches alone resulted in the highest rates of participation in substance abuse treatment.

Whether grantees supported a new or enhanced FDC was also associated with engagement in substance abuse treatment with grantees implementing FDCs engaging participants at significantly higher rates than those that did not.

Table 9 shows that the rate of participation in substance abuse treatment is highest among the eight RPG grantees that have expanded or enhanced an FDC. The second highest rate of participation in treatment is associated with grantees that have implemented new FDCs, and the

lowest proportion of adults that participated in substance abuse treatment is associated with grantees that *did not* implement an FDC strategy. The number of grantees and adults in each strategy condition support the reliability of this analysis and the validity of the conclusion that FDCs successfully encourage participation in substance abuse treatment.

Table 9: Participation in Substance Abuse Treatment After RPG Program Entry by Family Drug Court Strategy

Family Drug Court Strategy (n= Number Of Grantees Implementing The Strategy)	Episodes Of Substance Abuse Treatment			
	None Percent (*n*)	1 Episode Percent (*n*)	2 Or More Episodes Percent (*n*)	Total Percent (*n*)
No Family Drug Court (31)	33.9% (3,292)	55.5% (5,383)	10.6% (1,028)	100.0% (9,703)
New Family Drug Court (8)	15.1% (256)	59.8% (1,016)	25.1% (427)	100.0% (1,699)
Expanded, Enhanced Or Expanded And Enhanced Family Drug Court (8)	4.4% (47)	77.4% (825)	18.2% (194)	100.0% (1,066)

Finally, the proportion of adults participating in substance abuse treatment was dramatically higher in the ICM plus FDC condition. A large and statistically significant difference in the extent of participation in substance abuse treatment was observed between adults served by the 20 grantees that implemented ICM without an FDC and adults served by five grantees that provided ICM with a family drug court; X^2 (2, N=7,859) = 203.647, $p < .001$.

Rates of participation in substance abuse treatment are significantly higher in family drug court settings.

Length of stay in treatment was also associated with the type of parent support strategy implemented by grantees. Recovery coaches appear to outperform any other parental support strategy especially when combined with ICM. Specifically, the median lengths of stay in treatment across discharge categories by parent support strategy ascend from a low of 102 days in treatment for adults served by grantees that did not implement any parent support strategies to 164 days for adults in one RPG program that implemented a "Recovery Coaches Only" strategy, to 200 days in treatment for adults supported by a combination of ICM and Recovery Coaches. A comparison of means verified the statistical significance of these differences; F (5, 6,707) = 39.535, $p < .001$.

Also like engagement in substance abuse treatment, the length of stay in treatment and a positive discharge status were also generally positively associated with implementing an FDC strategy.

Table 10 depicts a linear increase in the median length of stay in substance abuse treatment by FDC status, from a low of 126 days among thirty RPG grantees that did not implement a family drug court to 144 days among the adults served by new FDCs to 216 days among expanded or enhanced FDCs. Again, a comparison of means associated with these strategies is statistically significant; F (2, 6,898) = 127.982, $p < .001$.

Table 10: Median Length of Stay in Most Recent Episode of Substance Abuse Treatment After RPG Program Entry, by Grantee Family Drug Court Strategy

Family Drug Court Strategy (n= the number of grantees implementing the strategy)	Median in Days (*n*)
No Family Drug Court (30)	126.0 (4,866)
New Family Drug Court (8)	144.0 (967)
Expanded, Enhanced or Expanded and Enhanced Family Drug Court (8)	216.0 (813)
Total	**137.0 (6,646)**

The median length of stay in treatment among the seven grantees implementing ICM combined with peer or parent mentors in an FDC setting (*ME*=163 days) is more than twice the median length of stay when ICM and a peer or parent mentor strategy is implemented without the structure of an FDC (*ME*=72 days), and the comparison of means between these conditions is statistically significant.

The highest proportions of positive substance abuse treatment outcomes are associated with recovery coaches alone and a combination of ICM and recovery coaches.

The last row of Table 11 shows that 43.3 percent of all adults (n=2,938) completed treatment, while an additional 7 percent (n=473) were transferred to another program or facility for further treatment and known to report (considered a positive treatment outcome per Federal treatment episode reporting). A total of 33.7 percent (n=2,286 adults) dropped out of treatment, while the remaining 18.2 percent (n=1,859) of discharges occurred for other reasons. "Other" discharge status included treatment terminated by action of the facility or because the client was

incarcerated, death or the client left treatment for other specified reasons unrelated to treatment compliance.

Table 11 presents the parental support strategy combinations in ascending order of the proportion of positive treatment outcomes (the sum of "Completed" and "Transfer"). Positive outcomes ranged from a low of 45.5% (no parent support strategy) and 45.6 percent (ICM only) to highs of 63.3 percent (ICM and recovery coaches) and 91.1 percent (recovery coaches only). These differences are statistically significant; X^2 (15, N=6,791) = 434.188, $p < .001$.

Table 11: Last Discharge from Substance Abuse Treatment after RPG Program Entry, by Parent Support Strategies

Parental Support Strategy Combination (n=number of grantees implementing the strategy)	Discharge Category				Total Percent (n)
	Completed Percent (n)	Transfer Percent (n)	Drop Out Percent (n)	Other Percent (n)	
No Parent Support Strategy (3)	41.3% (188)	4.2% (19)	47.7% (217)	6.8% (31)	100.0% (804)
Intensive Case Management Only (27)	37.3% (1,480)	8.3% (327)	35.6% (1,412)	18.8% (744)	100.0% (3,963)
All Three Parent Support Strategies (3)	47.5% (329)	5.9% (41)	23.8% (165)	22.8% (158)	100.0% (693)
Intensive Case Management and Peer/Parent Mentors (9)	48.1% (470)	8.0% (78)	36.7% (359)	7.3% (71)	100.0% (978)
Intensive Case Management and Recovery Coaches (7)	61.9% (358)	1.4% (8)	23.0% (133)	13.7% (79)	100.0% (578)
Recovery Coaches Only (1)	91.1% (113)	0.0% (0)	0.0% (0)	8.9% (11)	100.0% (124)
Total Discharge Category Percent and (n)	**43.3% (2,938)**	**7.0% (473)**	**33.7% (2,286)**	**(16.1% (1.094)**	**100.0% (6,791)**

Table 12 depicts the counts and proportions of adults discharged from substance abuse treatment in four categories. The sum of "Completed" and "Transfer" indicates the proportion of positive treatment outcomes, which ascend from 47.7 percent among adults in RPG programs that did not implement an FDC to 57.3 percent among adults participating in new FDCs, and then diminish very slightly to 55.1 percent or adults enrolled in expanded or enhanced FDCs. These differences are statistically significant; X^2 (6, N=6,707) = 93.631, $p < .001$.

Additional analyses of these data present some findings inconsistent with the conclusion that FDCs are always associated with the highest outcomes. For example, the combination of ICM peer or parent mentors and recovery coaches to support parents outside an FDC is associated with a significantly higher proportion (65.7 percent) of positive treatment outcomes than the same parental support implemented within an FDC context (45.8 percent). Also, the median length of stay in treatment is significantly higher outside the FDC when no parent support strategies are combined with the court setting. The extent to which these last findings can be generalized is constrained, however, by the small number of grantees and adults involved in the comparison.

Table 12: Last Discharge from Substance Abuse Treatment after RPG Program Entry, by Grantee Family Drug Court Strategy

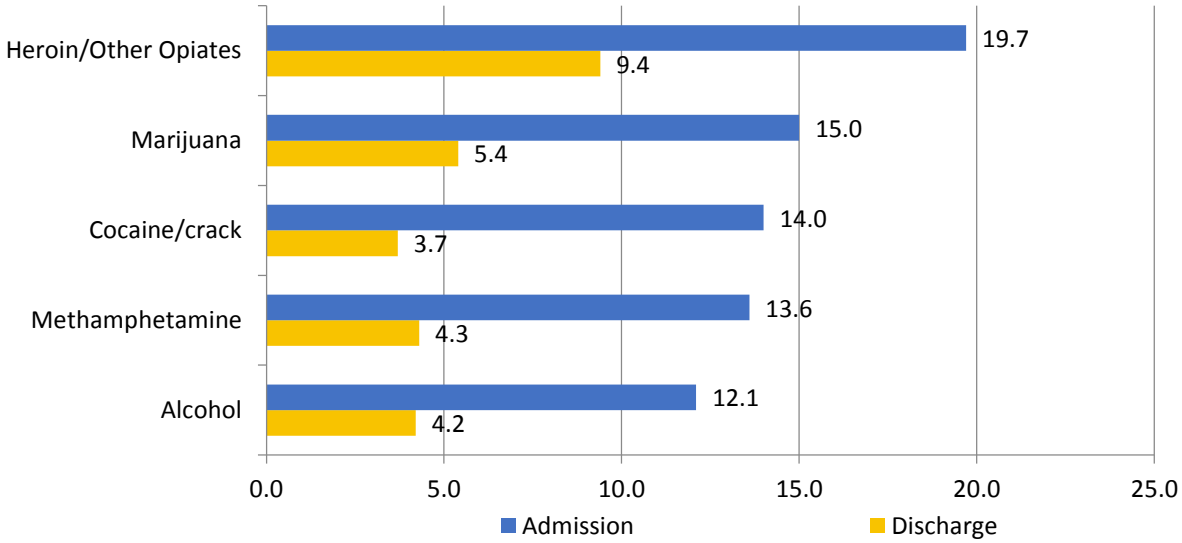
Family Drug Court Strategy (n=the number of grantees implementing the strategy)	Discharge Category				Total Percent (n)
	Completed Percent (n)	Transfer Percent (n)	Drop Out Percent (n)	Other Percent (n)	
No Family Drug Court (30)	40.3% (1,866)	7.4% (345)	35.4% (1,641)	16.8% (780)	100.0% (4,632)
New Family Drug Court (8)	51.4% (611)	5.9% (70)	25.6% (304)	17.2% (204)	100.0% (1,189)
Expanded, Enhanced or Expanded and Enhanced Family Drug Court (8)	50.1% (444)	5.0% (44)	34.5% (306)	10.4% (92)	100.0% (886)
Total Discharge Category Percent and (n)	**43.6% (2,921)**	**6.8% (459)**	**33.6% (2,251)**	**16.0% (1,094)**	**100.0% (6,791)**

Reduced Substance Use

Reductions in the mean number of days of use in the 30 days prior to treatment admission compared to the 30 days preceding discharge are illustrated by Figure 18. Heroin and other opiate use decreased from a mean of 19.7 days to 9.4 days, marijuana use decreased from 15 days to 5.4 days, cocaine/crack use declined from 14 days to 3.7 days at discharge, methamphetamine from a mean of 13.6 days to 4.3 days and alcohol use decreased from a mean of 12.1 days in the 30 days preceding admission to treatment to a mean of 4.2 days in the 30 days preceding discharge. The percentage of participants reporting abstinence from alcohol use at treatment admission (60.3 percent) was slightly higher than the latest data45 for the RPG States (58.6 percent) and at treatment discharge (83.7 percent) was slightly lower than the States' data (84 percent). RPG participants showed a smaller percentage increase 46 in the number abstinent

for alcohol from admission to discharge (38.8 percent), compared to the 25-state subgroup 43.3 percent.[47]

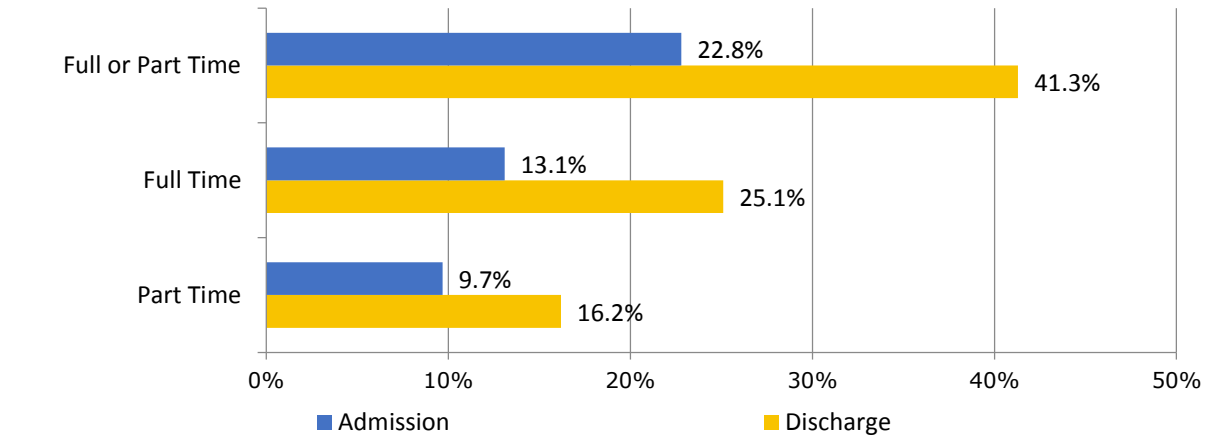
Figure 18: Mean Number of Days of Substance Use in 30 Days Preceding Treatment Admission and Discharge, by Selected Substances



Employment

Stable employment provides the financial backbone for family recovery and adds meaning to the lives of most adults. Therefore, many grantees included employment assistance among the services they provided. The percentage of adults in the RPG Program for whom data are available that were employed full time increased significantly from 13.1 percent at substance abuse treatment admission to 25.1 percent at treatment discharge (Figure 19), a 91.6 percent rate of change from admission to discharge.[48] The percentage of adults who were employed part time increased significantly from 9.7 percent at substance abuse treatment admission to 16.2 percent at discharge, a 67 percent rate of change from admission to discharge.

Figure 19: Percentage of Adults Employed at Substance Abuse Treatment Admission and Discharge (N=2,701)



Criminal Behavior

Criminal behavior is often associated with substance use and puts children at risk for neglect and abuse. Grantees attempted to monitor[49] the arrests among adult participants and where data is available, indicators suggest that such behavior decreased during their participation in the RPG program. Specifically, among 695 adults in the RPG Program with any arrests at treatment admission and for whom arrest data at discharge was available, 80 percent showed a decrease in criminal behavior at treatment discharge (as measured by number of subsequent arrests). Furthermore, the total percentage of adults with no arrests increased significantly from 86.6 percent at treatment admission to 95.4 percent at treatment discharge. This rate of change is greater than the latest data for the RPG States (Table 13).[50]

Table 13: Percentage of Adults With No Arrests in the Prior 30 Days at Treatment Admission and Discharge (Median Performance)

Percentage of Adults with No Arrests in Past 30 Days	RPG Adults	21-State Contextual Subgroup Data
At Treatment Admission	86.6%	91.2%
At Treatment Discharge	95.4%	95.5%

Notes: RPG data represent 35 grantees. The State Contextual Subgroup Data reflect the 21 States in which these RPGs are located. Data were retrieved from the States' Substance Abuse Prevention and Treatment Block Grant Application Forms T3 (FY2013) and represent either calendar or fiscal year 2011 for most States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2013). The State contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants.

HOW DID GRANTEES INCREASE ORGANIZATIONAL CAPACITY?

Grantees sought to improve their integrated cross-systems capacity through collaborative practices because program participants presented complex problems requiring a coordinated approach to service provision. The RPG performance monitoring framework addressed organizational capacity to address these problems based on:

- Regional Partnerships' Collaborative Capacity
- Coordinated Case Management
- Substance Abuse Education and Training for Foster Parents and Other Substitute Caregivers

Grantees learned several key lessons about meaningful collaboration in serving these families. These lessons suggest that families involved in child welfare affected by parental substance use disorders have multiple and complex needs that typically have compounded over time. This required more intensive services and for a longer duration than originally anticipated. Furthermore, treating the family system, rather than an individual child or parent in isolation, is far more effective in addressing a family's underlying and complex issues.

Over the course of the grant period, grantees also moved from individual-focused services to more comprehensive family-centered treatment. They leveraged existing community resources to expand direct services to children and other family members. The new systems collaboration and improvements developed predominantly with RPG funds resulted in an increased number of partners working together to provide a more coordinated and comprehensive service array and increase families' timely access to these services. To build and sustain the necessary cross-systems collaborative infrastructure required a shared commitment of both financial and human resources, which most funding streams typically do not reimburse. It also required ongoing TA and support. The payoff for this investment, however, was increased access to a broader array of services not always paid for by the grant and new ways of doing business beyond traditional system silos.

The importance of staffing issues (e.g. recruitment, retention, and staff development) in building collaborative capacity cannot be underestimated, particularly for programs working in sparsely populated and remote rural areas. Staff training and development was a key project component in larger implementation and sustainability plans. Experienced and consistent project leadership was also critical to grantees' overall success. Finally, sufficient time, funding, and staff were required to develop collaborative performance monitoring and program evaluation capacity. The cross-systems communication and information sharing began with the RPG project and helped lay the foundation for sustained collaborative efforts that will extend beyond the grant.

Performance in these and other domains is summarized in the following subsections beginning with the highest priority, improving collaborative capacity to meet the needs of families.

COLLABORATIVE CAPACITY

All 53 grantees used the Collaborative Capacity Instrument (CCI) to inform their efforts to improve cross-systems collaboration. The CCI is a self-assessment tool used by State or local substance abuse and child welfare service agencies and dependency courts seeking to strengthen their collaborative relationships and capacity to provide comprehensive services to and improve outcomes for children and families.[51]

The regional partnerships showed significant improvement in all key areas of collaborative practice over the five-year grant period, as measured by the CCI[8]. Their progress in building collaborative capacity directly reflects the legislation's emphasis on developing and strengthening interagency collaboration and services integration. In general, grantees showed the most rapid and greatest amount of change during the first part of the grant period. Their broader collaborative capacity continued to improve during the latter part of the grant period, yet

[8] The CCI is based structured according to the Ten Element Framework of system linkages that are necessary for effective collaboration between the substance abuse treatment, child welfare, and dependency court systems. The ten elements of the framework are: Underlying values and principles of collaborative relationships; Daily practice–client screening and assessment; Daily practice–client engagement and retention in care; Daily practice–services to children of substance abusers; Joint accountability and shared outcomes; Information sharing and data systems; Training and staff development; Budgeting and program sustainability; Working with related agencies; Working with the community and supporting families. National Center on Substance Abuse and Child Welfare, 2003. *Framework and Policy Tools for Improving Linkages Between Alcohol and Drug Services, Child Welfare Services, and Dependency Courts.* http://www.cffutures.org/files/publications/ElementFrameworkful.pdf

typically at a more moderate rate. Two areas proved the exception: 1) underlying values and principles of collaborative relationships; and, 2) building community and family supports. Grantees showed greater progress in these two domains during the second (rather than first) part of the grant period.

The relative slowing down in the rate of progress likely reflects several developments. During initial program implementation, project teams were formed and enthusiasm was high. In later years, several sites experienced leadership changes and significant staff turnover; progress stalled as partnerships had to adjust to these events. Also, many sites were adversely impacted by the fiscal and economic environment. Budget cuts, staff and service reductions and other related effects hampered grantees' overall collaborative capacity. These contextual events tested the collaborative relationships of many sites, often requiring more intensive and extensive discussions as grantees worked through these issues.

In addition to higher mean scores in all areas, the percentage of Don't Know/Not Sure responses continually declined over the course of the grant period. This indicates that project staff and partners developed an increased understanding of how their partnership's various collaborative domains were functioning. Specifically, Underlying Values and Principles of Collaborative Relationships was rated as the strongest of the 10 areas throughout the grant period. Further, by year five, substance abuse treatment, child welfare, and court partners were much more likely to have used a formal values assessment process.

Screening and Assessment ranked among the top three collaborative practice areas in years one, three, and five. Client Engagement and Retention also was ranked consistently as one of the top three collaboration areas throughout the grant period. Partners' knowledge about each other's systems and their ability to talk with families about substance abuse, child welfare and court issues continued to be rated as a primary strength. For example, by year five, partners were more apt to agree that they were using drug testing effectively to monitor clients' treatment compliance. The partnerships showed the greatest amount of progress in assessing client dropout points, training staff in approaches to improve client retention and providing family-focused substance abuse treatment.

Services to Children showed the greatest amount of improvement over the course of the grant period, though overall, this area of collaboration was consistently rated the lowest of the 10 areas. The mean score increased 17.8 percent, from year one to year five. The area of Information Sharing and Data Systems showed the second greatest amount of change from baseline to final administration. The mean score increased a total of 15.2 percent, from year one to year five, as grantees strengthened their ability to collect, report and use their data for program improvement. In addition, the decline in Don't Know/Not Sure responses (from 46.7 percent in year one to 32.5 percent in year five) suggests project staff became more knowledgeable about their own and each other's data system capacities.

Staff Training and Development showed a significant amount of change over time, but remained among the lower rated areas compared to the other practice domains. Cross-systems clinical training, in particular between substance abuse treatment and child welfare agencies, was identified as a key strength. Budgeting and Program Sustainability showed the least amount of change over time. The mean score showed a slight increase of 7.1 percent from year one to year

five. Further, this area had the highest percentages of Don't Know/Not Sure responses (which decreased somewhat from 53.3 percent in year one to 43.1 percent in year five). These findings may reflect the challenges grantees faced with third-party billing for RPG services and the larger fiscal environment's impact on sustainability planning.[52]

Working with Related Agencies was a key collaborative strength throughout the grant period. In particular, partners indicated child welfare and substance abuse staff did extremely well in identifying and linking families with needed support services. The partnerships made the greatest amount of improvement from year one to year five in routinely assessing supportive service referral and completion rates and monitoring barriers to access needed services. In addition, by year five, partners indicated substance abuse recovery groups were more likely to include a focus on child welfare and safety issues.

Building Community and Family Supports showed significant gains, particularly in the latter half of the grant period. However, overall it was one of the lower rated collaborative areas compared to the other domains. Joint Accountability and Shared Outcomes showed substantial improvement over the course of the grant period. The mean score increased 13.7 percent from year one to year five. Within this collaborative area, partners were in strong agreement that parents were being referred to parenting and child development programs with demonstrated positive results.

Better collaboration impacted the grantees' ability to meet the participants' needs. Some of the key components of successful collaboration identified by grantees included:

Adaptability and Flexibility

Grantee Partnerships changed over time in membership and attitude. Changes in membership included the addition of new partners, loss of some due to turnover, layoff, or changes in program. The changes in attitude often were a result of participating in a collaborative approach to working with families and children affected by substance abuse. One grantee expressed, "we have seen a change in attitude by our primary substance abuse provider. When we started, they dreaded child welfare clients coming in because of the way they had to interact with child welfare. Now they are fully supportive of our population…they hired a case manager specifically to help our participants connect with resources. I think they are probably committed to that as well. That is an amazing change for them."

Another grantee noted that change at the collaborative level was important. "You need to constantly be open to expanding, changing, and introducing new individuals to that partnership." This grantee went on to state, "we really wanted people who [already existed] in the community [and] were already doing the work in some form or fashion."

Another grantee responded, "[we] went and found the individual entity in our community that best provided that service and then we reached out to see what they would need to participate and what role they would play. Then we integrated them in, as best as we were able to." This led to a partnership with a local domestic violence agency, which resulted in improved relationships with child welfare and the drug court.

Time to Develop Trust

Many grantees identified trust as a crucial component of a successful collaboration. One grantee noted that within this field, "[partners must learn to} trust with each other's discipline. You trust that they're within their discipline making every effort to be successful." Another noted that there was trust and communication with the community and with the federal staff, which allowed for the grant to work to better meet its goals.

Grantees observed that it was trust among the leaders and service providers that would help get the program through the disagreements and bumps. One grantee provided an example of working closely with a child welfare manager who would say, "you can ask us any questions about why we made these decisions and…we'll explain them to you." This understanding between child welfare and treatment providers allowed for open dialogue and sometimes decisions would be changed and others not, but as this grantee noted, "that is an essential piece of work that has to happen otherwise you build resentment."

Grantees also noted that getting the right partners can be challenging and requires time. As one grantee stated, "we decided that although we knew it was going to be difficult, we were [still] going to set out to make a real collaboration of partners and services for our target population. I think that that has been one of the biggest lasting legacies of the RPG grant because many times those directors and departments did not talk with each other and definitely did not share a vision for the work that we were doing."

Partner, Staff and Team Engagement

Grantees described the importance of engaging stakeholders and agency partners early and often. One grantee identified the development of an Advisory Board prior to the grant as one of the most important decisions. This grantee stated, "we captured their interest and what was important to them from the beginning and then making all partners have equal say at the table regardless of how much of the work in the grant they were doing." Another grantee noted, "I think that the most important decision we made was the amount of time and effort that was put in at the initial planning phase of this project, then throughout the implementation." This grantee noted that in a previous grant they could not engage a community partner but took a very different approach with the RPG grant. They shared, "we did focus groups and met with our planning partners and said we were interested in applying for this grant [and what] we think our greatest needs [were]. So, we began the collaborative process right at the writing of the grant, but I still think that the most important…important lessons that we learned [was that] the level of effort that really needed to be invested [was] at the right end of the project."

Another grantee identified the importance of provider meetings in bringing treatment providers to the table. As this grantee noted, "[in the past] substance abuse providers [have] been more isolated. They work out of their offices and do not really come out to collaborate. So…now [with the provider meetings] happening, and will continue to happen, [relationships are enhanced]."

Grantees also identified the importance of the ongoing partner meetings. One grantee noted, "[we are] bringing as many of the partners to the table [as possible] at least once a month, and

really whatever anybody wants to put on the agenda and talk about, is talked about…" Furthermore, the grantee added, "there's a commitment I think by everyone to discuss openly, at least try to discuss openly, what concerns are." This was also a place where grantees were able to invite those partners that may have been reluctant and engage them in the partnership. As one grantee reported, they struggled to engage court partners. They invited judges and attorneys and let them know about the partner meeting. The grantee stated, "We're developing the tools that we are going use together, so we weren't saying, 'here's what the assessment is going to look like." We said, "What do you need the assessment to look like? Let's try to design something that meets all of our needs before we even begin using something."

Leadership

Several grantees described the importance of engaging top leaders in the collaborative. One grantee noted that this was important for their project because engaging these leaders "[kept] them engaged in the process…they can make decisions at the table and they can disseminate a view, a philosophy that has to sort of permeate the partnership…" The grantee further added, "What we were trying to accomplish was a sea change in terms of attitude, practices [and] values and so we really needed top down." Another grantee found that the voices of the clients helped them engage leadership in the collaborative. As they noted, "showing them what's been happening on the ground through the voice of the children of the parents who can stand up at the end of their court process and say, 'this is what this meant to me, and this is how my life has changed as a result of what you guys are doing,'" was a great strategy for the grantee.

Grantees often identified a champion in their community and report that this helped move the attitude of other people, particularly those in the same field as the champion. One grantee experienced success with a champion who was a judge. A champion at this level was able to support the program and outcomes for children by recommending placement of the child with the mothers when the grantee was able to convince the judge the children would be safe. As the grantee noted, "…there is a jurisdiction where they tended to take more kids away than leave them at home and we convince the judge on shelter that we could keep those kids safe…the child welfare workers knew that they would dismiss them from the case or override and, I think, they never had to because we all came at it as a team and everybody sort of came to consensus on these."

A champion can also be the person to push the collaborative to address the challenging partners or situations. One grantee gave the example that they were having trouble engaging the defense attorneys. "There were philosophical issues, going back to, reengaging and it was tough for some of the partners to really get there mind around that." They state that their judge told them to go and figure it out. "Get them to the table and figure it out."

Grantees spoke about the importance of leaders' ability to retain and recruit partners throughout the RPG grant. At times, grantees found the need to engage new partners to be able to meet the needs of families, adults, and children while at other times they realized that partners no longer needed to be at the table. One grantee stated, "we had to look locally about who had interest in these areas [or] who were working in the same area, but maybe not collaborating...We had to identify who those people were and then once [we] knew who they [were, we] have to know

what their hook is, what their interest is or what they need to get out of participating or interacting in any type of collaborative."

Shared Goals and Formalized Policies and Practices

One grantee "created a charter [for the collaborative] and that charter brought together a vision and a mission for the drug courts and for parenting recovery as it supports the drug courts…Everyone was moving in the same direction and had the same values." The grantee noted that while developing the charter took time and energy, it allowed partners to discuss, disagree, and develop something to which they could commit.

Yet another grantee noted that collaboration is something that all partners must care about. This grantee stated, "[collaboration] is [about] developing goals that they can't reach by themselves…child welfare needs to reduce foster care. They cannot do it without us [and] we cannot do it without them. We can't return children more quickly without the court's involvement…so I think it's really important to come up with something that people can enthusiastically buy off on and helps them reach their agency goals while they're reaching their partnership's goals because that keeps them invested in it." Some grantees recognized the value of developing a process for conflict resolution. One grantee noted that seeing families fight through their court battle made them realize that there were other ways to address the conflict and that this had to apply to the collaborative as well. The grantee noted, "we've been able to take that away by building this partnership where people work with each other very, very differently. There are definitely disagreements, and there are definitely pieces of things that we struggle with, but we worked hard to develop a process for conflict resolution."

Collaboration was a central theme for grantees and a focus of the performance monitoring system. However, two other important components of organizational development included coordinated case management and education or training. These issues are addressed in the next two subsections.

Coordinated Case Management

The majority of families in the RPG programs received coordinated case management services. On average, 94.1 percent of all families served reported active involvement in various aspects of the case planning process. Sixteen of the 27 grantees submitting these data reported that 100 percent of their families were actively involved in coordinated case planning.[53] Of those families served who had open cases in both the child welfare and substance abuse treatment systems, an average of 94.4 percent received joint case management services coordinated between the systems. Twenty of the twenty-seven grantees providing these data reported that 100 percent of their families received joint case management services.

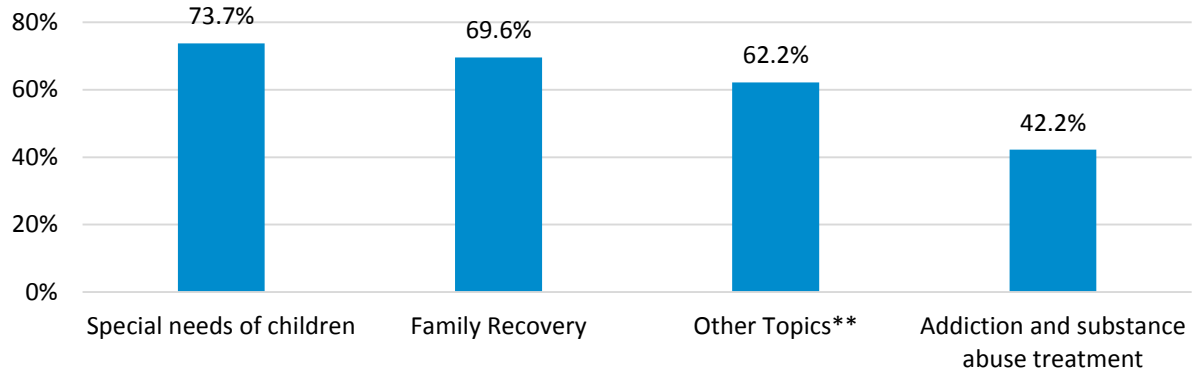
Furthermore, of those grantees that reported about families receiving joint case management services, an average of 95.6 percent received a cross-agency assessment conference every 90 days or less. Twenty-one of the twenty-five grantees providing these data indicated that 100 percent of their families received such a cross-agency assessment conference.

Substance Abuse Education and Training for Foster Parents and Other Substitute Caregivers

Over the course of the grant period, twelve regional partnerships provided 270 substance abuse education and training events in which 1,901 foster care parents and other substitute caregivers participated. Nearly three-fourths (75.6 percent) of all trainings addressed issues related to the special needs of children who have been maltreated and are impacted by a parent's or caregiver's substance use. More than two-thirds (69.6 percent) of trainings covered family recovery, while 42.2 percent covered issues regarding addiction and substance abuse treatment. Finally, more than three-fifth (62.2 percent) addressed other related topics such as the impact of trauma on children and trauma-informed care, parenting skills and collaboration between foster parents and biological parents (see Figure 20).[54]

Grantees noted that some training areas were more pressing than others (e.g., trauma and the importance of early childhood education). One grantee noted that there is still much to be known about young children when he/she said, "I do think we have a long way to go with young children, the five and under crowd, and their specific need within the child welfare," and thus, trainings must be ongoing as information about this population is made available. Additionally, grantees noted the importance of recognizing trauma and providing appropriate training and treatment. "We're back to people acknowledging trauma and the impact it has. We have a long way to go, at least in this State and probably true in other States, as far as coming up with ways [for] interacting with traumatized families in a way that is more helpful and effective. I think we're still in the infancy stage in this area with folks."

Figure 20: Substance Abuse Education and Training Events Provided to Foster Care Parents and Other Substitute Caregivers, Percentage by Topic Area* (N=270 training events)



* Percentages do not add up to 100 because grantees can provide trainings that address multiple topics

** Includes topics such as the impact of trauma on children and trauma-informed care, parenting skills and collaboration between foster and biological parents

HOW DID GRANTEES SUSTAIN THEIR EFFORTS AFTER FEDERAL FUNDING?

The funding opportunity announcement for the RPG Program required that the applicants describe "a sound plan for continuing this project beyond the period of Federal funding. The plan for sustainability includes a discussion of plans to leverage other available funds to continue services and activities." HHS emphasized from the outset of the program the importance of sustaining these collaborative practices after the grants expired. However, most sites did not begin to substantively address sustainability issues until after the second year of their grant.

The environment in which these grants were implemented changed drastically with the onset of the Great Recession in 2008. Grantees repeatedly emphasized the difficulty of planning for sustainability in the given economic and fiscal climate. Grantees noted they began the grant project fully aware of the critical need to develop sustainability plans as early as possible. However, they did not anticipate how drastic the economic downturn would be at both the state and local levels. The majority of grantees reported that Federal, State and county budget cuts was one of the most significant barriers to their sustainability planning at some point during the grant period. The percentage experiencing this major sustainability challenge rose steadily over the course of the grant (i.e., from 35.6 percent in program year two to 69.8 percent in year three to a high of 76.6 percent in year four). In program year five, it subsided to 48.8 percent, as some States' fiscal outlook improved. Despite this economic environment, grantees achieved a substantial level of success with sustaining at least some aspect of their collaborative activities.

Grantees who sustained their program components generally were able to institutionalize and integrate RPG practices into existing systems of care. For example, nine grantees achieved larger systems changes (e.g., institutionalized RPG practices and services with system-wide implementation that went beyond the funded project). In these sites, integrated services, coordinated case planning, improved cross-systems communication, and shared agreement on client outcomes became the preferred way of operating. Child welfare, substance abuse treatment, the courts, and other systems adopted and expanded many of the practices established through the RPG project for all parents and children involved in their system or similar programs.

COMPONENTS SUSTAINED BEYOND GRANT FUNDING

In 2012, eight grantees received 2-year extensions of their grants or received new funding as part of the second cohort of grantees. Among the 45 regional partnerships whose grants were not extended beyond the original funding period:

- Fifteen grantees (33.3percent) sustained their project in its current form or model beyond their grant period. In some cases, the collaborative partnerships, the target populations and/or the services provided were enhanced or expanded
- Another 24 grantees (53.3 percent) were identified as having sustained specific components or a scaled down or modified version of their overall program model
- Five grantees (11.1 percent) were not able to sustain any of their program
- One grantee's (2.2 percent) sustainability status was uncertain as they continued to pursue their options
- Nearly three-fourths (73.2 percent) of the major services and activities provided as part of the RPG Program would be sustained after the grant; family-strengthening services, children's

services and substance abuse and mental health treatment and linkages were the program areas with the greatest likelihood of being sustained

- 9.0 percent of program strategies would not be sustained
- Grantees achieving higher levels of collaboration had substantially higher rates of sustainability than those grantees at lower levels of collaboration

BARRIERS TO AND FACILITATORS OF SUSTAINABILITY

As mentioned above, the most significant barrier to successful sustainability was the economic environment that impacted grantees on multiple levels. Grantees reported that the challenging fiscal climate that persisted throughout the grant period had adversely affected their regional partnerships' services and outcomes. They noted that State and county budget cuts reduced substance abuse treatment capacity, affected child welfare staffing patterns, impacted contract service dollars and reduced the level and type of available community support services (outside of RPG-funded services) on which the grantees' clients rely; specifically:

- Since 2008, at least 46 states (27 of the 29 RPG states) plus the District of Columbia have enacted budget cuts that affect services for children and families[55]
- Thirty-one states (19 of the 29 RPG states) confronted budget shortfalls for the fiscal year that began July 1, 2012[56]
- During the grant period, more than three-fourths (79.2 percent) said the community's broader economic climate impacted their RPG program and target population; close to half (47.2 percent) cited unemployment and shortage of jobs as a key community contextual event and 39.6 percent mentioned housing issues
- During the grant period, nearly all of grantees (88.7 percent) reported that budget cuts and/or staff layoffs affected their projects; the percentage of grantees impacted increased from two-thirds (66 percent) in program year two to a high of 83 percent in year four, before decreasing to 44.2 percent in the final program year
- For most grantees, cuts continued throughout the grant period; well over half (56.6 percent) of grantees were impacted by agency reorganizations during the grant period; more than two-thirds (67.3 percent) of the grantees reported these reductions and changes decreased collaborative activities or collaborative service delivery

As a result of these issues, partners had less time or inclination to participate in sustainability planning or cross-systems training. They made fewer referrals or had to reassign front-line staff that worked with RPG families. Grantees highlighted, in particular, difficulty with engaging state agencies and other key stakeholders in sustainability discussions. While local partnerships may have felt a sense of urgency in sustaining their activities, they reported the state agencies often did not. Grantees described state agencies as being in "survival mode," focused on internal budget solutions and immediate day-to-day operations.

While the majority (83 percent) of grantees had engaged key stakeholders in sustainability discussions, many faced challenges in channeling those discussions into active sustainability support. For example, during program years four and five, a lack of collaborative relationships, credibility, or connections at the local community or larger state level, the lack of political or

leadership was identified as a major sustainability barrier for 37.7 percent of grantees. This was a substantial increase from 11.3 percent in year two and 15.1 percent in year three. In addition, changes in state agency leadership (due to turnover or retirements) were often problematic for grantees. The relationships and support they had cultivated with key decision makers gave way to uncertainty as new leaders came in. This type of environment made it difficult to engage others in discussions about longer-term outcomes, the benefits of sustaining or expanding programs, redirection of funds, or how to absorb the RPG services and functions. As a number of grantees demonstrated, the ability to identify and engage key leadership and stakeholders in sustainability conversations grounded in specifics (e.g., results, costs) was instrumental in their success in sustaining their program models.

Grantees noted having experienced and consistent project leaders and direct service staff was a critical contributing factor to the partnership's success and achieving positive family outcomes. Further, many partnerships acknowledged that recruiting, training, supporting, and retaining highly skilled professionals proved to be more difficult than they anticipated. Achieving full staffing was one of the most challenging goals to achieve. Staff turnover was pervasive throughout the grant for the majority of the partnerships, specifically:

- Nearly all (86.8 percent) of grantees reported challenges with turnover or retention in front-line or direct service staff; turnover seemed to peak in program year three, but was also high during the first part of the final program year, most likely because of uncertainty about continued funding
- Nearly two-thirds (62.3 percent) of grantees also experienced turnover or retention difficulties with key management or administrative positions

By the end of the grant, the majority of grantees (90.6 percent) had moved beyond exchanging information about each other's systems to more advanced stages of collaboration.[57] A substantial number (30.2 percent) of grantees had undertaken joint projects or shared grants to better meet families' needs and help sustain RPG services. Most (43.4 percent) progressed a step further and changed the rules for how children and families are served. For example, grantees redirected funding or implemented interagency agreements and processes for case management of shared clients. Nine grantees (17 percent) were able to institutionalize RPG practices and services with system-wide implementation that went beyond the funded project.

The level of collaboration grantees were able to establish was directly related to their sustainability results. For example, of the five grantees who were still in the preliminary stages of collaboration (i.e. information exchange), only two were able to sustain all or part of their RPG model. In contrast, of those who were able to determine their sustainability status and who attained the fourth (top) sustainability stage, nearly three-quarters (71.4%) are expected to sustain their entire program model.

SUCCESSFUL FINANCING STRATEGIES FOR SUSTAINABILITY

RPG projects that consistently worked on sound sustainability plans were able to make significant progress in sustaining their project beyond the period of federal funding. Examples of successful sustainability strategies include: 1) widening the definition of available or potential resources; 2) changing the business as usual practices to incorporate RPG innovations; 3) redirecting existing, currently funded resources to adopt new case management and client engagement strategies; 4) negotiating third party payments for what the grant had initiated; and, 5) institutionalizing RPG practices into existing systems of care.

The grantees that did successfully integrate their efforts with other related program and policy initiatives used the RPG experiences to inform broader efforts pursued various strategies. The primary strategies are highlighted below:

- Integrating with Other Child Welfare Systems Improvements – Several grantees integrated their efforts into their State's Child and Family Services Review (CFSR), Performance Improvement Plan (PIP) or other similar child welfare systems improvement processes to sustain major RPG service components.
- Connecting with Other Related Grants or Initiatives – A substantial number of grantees mentioned in their progress reports a new grant or related initiative in their community that positively impacted their RPG project operations at some point during the grant. Grantees sought to integrate and connect with these endeavors to leverage additional resources. Several specifically mentioned collaborating with other related federally-funded grant projects designed to improve services and outcomes for families affected by substance abuse.[58]
- Incorporating RPG Efforts within their Own Agency – Several of the regional partnership lead agencies also leveraged and integrated the RPG-specific efforts with complementary initiatives within their own larger agency or organization. For example, one Tribal grantee was able to institutionalize the RPG Program's comprehensive assessment and service planning into their larger agency's standard intake process and continuum of services as well as the State's child safety practice model.
- Transitioning Services and Staff to Other Partner Organizations – By the end of the grant period, some grantees had successfully transitioned RPG staff positions, services and knowledge to partnering agencies that will continue to serve families beyond the grant. This integration strategy seemed to be particularly effective for smaller community-based grantee lead agencies that determined long-term sustainability could be better achieved by moving the program to another agency with increased capacity to secure funding and affect larger systems change.
- Joining with Larger Health Care Reform and Care Coordination Efforts – The Patient Protection and Affordable Care Act became law about midway through this initial RPG Program grant period (March 2010). The Affordable Care Act provides the regional partnerships with several new potential opportunities to integrate substance abuse treatment services within the broader health care system, while providing greater access to family-centered treatment services for families in or at risk of entering the child welfare system. It follows that in some RPG sites sustainability planning became a natural part of the health

care reform discussions and evolved into an integral component of their long-term sustainability strategy for services.

Examples of Grantees' Successful Efforts to Integrate with Health Care Reform:

One grantee collaborated with one of the State's primary Medicaid managed care organizations (MCO) to integrate physical and behavioral health care plans in the grantee's three RPG counties. The grantee and MCO identified shared goals and combined resources for staff trainings. The way in which providers in the three counties have collaborated to engage and retain hard to reach families is having an influence on managed care planning in the larger region.

Another grantee completed the planned integration of its children's social, emotional and behavioral health services and family support services into an existing Federally Qualified Health Center (FQHC). Health records are coordinated, clinicians are cross-trained and children's assessments are billable to Medicaid under the FQHC designation. No further grant money was used to support and sustain this work past the grant. However (as discussed further below), the grantee notes that current billing rates, even under a FQHC, do not adequately cover the cost of the comprehensive children's assessments.

A grantee's lead agency became part of their region's new Medicaid managed care system. Their involvement enabled them to integrate their family care coordinators into the broader comprehensive health services integration model. The care coordinators will continue to be housed at the State's child welfare and family services agency and RPG sites. They will continue to serve as the primary referral point and facilitate and track referrals between partners in the region's eight counties. The grantee called this integration of behavioral and physical health "a true sign of extraordinary systems change."

THIRD-PARTY BILLING – AN ESSENTIAL YET CHALLENGING COMPONENT OF SUSTAINABILITY

With the anticipated expansion of Medicaid insurance coverage for low-income families in many states, many of the above integration strategies involved establishing or expanding third-party billing capacity. Many grantees noted the ability to bill Medicaid or other third parties for reimbursable services was essential to their program's sustainability. Yet grantees vary widely in their capability to expand the number of Medicaid substance abuse providers or access Medicaid reimbursement. By the end of the funding period, nearly one-third (30.2 percent) of grantees had established a mechanism for third-party billing for various services, such as certain therapeutic services, substance abuse treatment services and (in at least one site) the Strengthening Families Program.

However, grantees continued to experience two significant and unresolved challenges with third-party billing. The first is establishing reimbursement structures and rates that cover the more intensive, comprehensive services that are key components of their RPG programs. The general trend seems to be that RPG services that can be supported by Medicaid funding are continuing, while the more intensive clinical services (e.g., residential treatment services) will continue to be

available on a more limited basis.

The second challenge is downward pressure on Medicaid reimbursement rates that occurred during this time related to reductions in most state budgets. The lesson, according to one grantee, is that sites must proactively monitor state reimbursement rates, as changes in state Medicaid reimbursement rates can severely impact RPG services.

The Promise – and Challenge – of Conducting a Cost Study

Although not a requirement of their evaluation plans, many grantees recognized the importance of conducting a cost study (i.e., cost determination, cost-effectiveness analysis or cost-offset analysis) as part of their overall program evaluation and sustainability efforts, Most grantees did not include a cost study as a component of their local evaluation plan. Many partnerships found they lacked the knowledge, capacity, collaborative relationships (particularly among budget staff), and financial and human resources to develop and complete such an analysis. Producing a detailed cost study is a significant challenge due to the complexity of documenting all costs and benefits across multiple systems. The local RPG programs included service providers from many different agencies and community-based organizations, an array of integrated and specialized services and support from several different funding streams (in addition to the RPG funding), as well as in-kind expenses and matching dollars.

Grantees also noted difficulties in obtaining partner buy-in and support for a cost analysis. This largely may have been a function of the fiscal environment during the grant period. Despite the agreed-upon importance of cost studies to facilitate sustainability, implementation of other program and evaluation tasks often took precedence in a constrained fiscal environment.

Nonetheless, by the end of their grant, nearly one-third (32.1 percent) of grantees had either completed, were currently conducting or were in the planning stages of a cost analysis. Grantees were in different stages of their cost studies at the writing of this report. Yet several grantees reported promising results, primarily related to cost benefits of reduced lengths of stay in foster care and increased and timelier reunification rates.

These cost studies are important steps in addressing many of the most pressing questions and issues that should be addressed as grantees and the field continues to grapple with finding the best ways to improve outcomes for these vulnerable families. The next section discusses how the findings described in this report help form a foundation for the important work that remains ahead.

Summary of Promising Grantee Cost Study Findings

Grantees were in different stages of their cost studies at the writing of this report. Yet several grantees reported promising results, primarily related to cost benefits of reduced lengths of stay in foster care and increased and timelier reunification rates.

One grantee reported cost avoidance of $3.51 million to $6.75 million in out-of-home care costs as result of their program. For every $1.00 spent on the program, the State avoids up to $2.52 on the cost of out-of-home care.

One grantee completed a cost-effectiveness study of the Strengthening Families Program and found the typical program child participant spent 190 fewer days in out-of-home care compared to a propensity score matched comparison group of children in out-of-home care. An average out-of-home care State rate of $86 per child per day, the program saved approximately $16,340 in out-of-home care costs per child. Every $1.00 invested in the program yielded an average savings of $9.83.

One statewide grantee found its FDC participants performed better than their comparison group in several outcome areas (e.g., higher reunification rates, fewer children removed from their parent's custody and shorter foster care lengths of stay). The grantee estimated the RPG Program saved the State more than $2 million dollars in child welfare and substance abuse treatment cost avoidance over the course of the grant period. Furthermore, they concluded that "there appears to be a relationship between greater resources spent on the parent's or caregiver's substance abuse treatment and both current and future child welfare cost avoidance…This [cost analysis] likely understates the cost avoidance because it focuses solely on substance abuse treatment and child welfare cost data."

Another FDC site estimated more than $154,000 in annual cost avoidance related to filing of fewer dependency petitions. In program year four, the grantee found 16.9 percent of children in the RPG program had petitions filed compared to 33.6 percent of comparison group children (the site estimated a per petition cost of $2,614). The site is continuing to work with child welfare to obtain data to calculate out-of-home care costs.

Still another FDC site reported children in their RPG program spent significantly fewer days in foster care and were more likely to reunify children in the comparison group. The expedited reunification for participant children generated a cost savings of approximately $251,600 due to shorter lengths of stay in foster care. The expedited adoption rate generated a savings of approximately $438,700.

One site calculated a total of 19,318 days in foster care were saved by allowing parents to reunite with their children more quickly in their supervised housing program. The grantee reported a cost savings of approximately $313,300 to the foster care system (at their daily rate of $16.22).

CONCLUSIONS AND RECOMMENDATIONS

This report summarizes information drawn from the largest dataset about US families involved with child welfare and affected by substance use including information on more than 15,000 families comprised of more than 25,000 children and 17,000 adults. What was learned about improving outcomes for children and families in the child welfare system who are affected by substance use disorders? The results and key lessons highlighted here show that the 53 partnerships – through their strengthened cross-systems collaboration – greatly improved the lives of thousands of children and families in their regions. Their collective experiences advance the field's understanding and evidence base of what works for these families and why. Their lessons can inform collaborative policy and practice shared by substance abuse, child welfare, and family court systems in communities across the nation.

Grantees' performance makes clear that the time, resources, and effort invested to develop broad-based interagency partnerships and integrated services resulted in positive child, parent, and family outcomes.

Key results included:

- The majority of children at risk of removal remained in their parent's custody. Most children in out-of-home placement achieved timely reunifications with their parent(s). After returning home, very few children re-entered foster care.
- Parents/caregivers achieved timely access to substance abuse treatment, stayed in treatment (on average, more than 90 days) and reported reduced substance use and gains in employment. They received essential clinical treatment and support services (e.g., continuing care, transportation, parenting training, mental health services, housing assistance) to promote and sustain their recovery and facilitate reunification.
- Adults in smaller families appear to be significantly more easily engaged and retained in substance abuse treatment than those associated with more children.
- In single parent enrolled families, female parents are more successful and stay in substance abuse treatment longer than male parents in similar families.
- Substance abuse treatment engagement, retention, and completion were significantly better among grantees supporting parents with recovery coaches and among those implementing FDCs.
- Some children from families participating in the RPG programs experienced somewhat longer lengths of stay in foster care (relative to the broader child welfare population). These stays seemed related to the intensive nature of many grantees' program models and long duration of services needed to meet families' needs.
- Overall child, adult, and family well-being improved from RPG program admission to discharge (for the subset of grantees who measured child well-being). However, the grantees' experiences in measuring well-being reflected a field in development and the inherent challenges associated with assessing change in such complex constructs. Their efforts, perhaps best viewed as an important and ongoing learning process, provide several important insights for strengthening future measurement of this critical outcome area.

The active engagement of core partners from the child welfare, substance abuse treatment, court and other service systems was essential to the partnerships' overall success.

Grantees learned several key lessons about meaningful collaboration in serving these families. Key lessons included:

- Families involved in child welfare affected by parental substance use disorders have multiple and complex needs compounded over time. This required more intensive services and for a longer duration than many grantees originally anticipated.
- Treating the family system, rather than an individual child or parent in isolation, is far more effective in addressing a family's underlying and complex issues. Over the course of the grant period, grantees moved from individual-focused services to more comprehensive family-centered treatment. They leveraged existing community resources to expand direct services to children and other family members.
- No one provider or service system alone can address families' multiple needs. The new systems collaboration and improvements developed predominantly with RPG funds resulted in an increased number of partners working together to provide a more coordinated and comprehensive service array and increase families' timely access to these services.
- Building and sustaining the necessary cross-systems collaborative infrastructure requires a shared commitment of both financial and human resources, which most funding streams typically do not reimburse. It also requires ongoing TA and support. The payoff for this investment, however, was increased access to a broader array of services not always paid for by the grant and new ways of doing business beyond traditional system silos.
- The importance of staffing issues in building collaborative capacity cannot be underestimated, particularly for programs working in sparsely populated and remote, rural areas. Staff training and development need to be a key project component in larger implementation and sustainability plans. Experienced and consistent project leadership was critical to grantees' overall success.
- Sufficient time, funding, and staff are required to develop collaborative performance monitoring and program evaluation capacity. The cross-systems communication and information sharing begun with the RPG project helped lay the foundation for sustained collaborative efforts that will extend beyond the grant.
- Both quantitative and qualitative data are essential to capture the full breadth, depth, and scope of grantees' programs and cross-systems collaborative progress. Comprehensive information and evaluation data provided important evidence of families' challenges and the RPG project's important role in improving the lives of children and families.
- Collaboration across agencies can extend beyond a single project to address larger system-wide barriers to working together effectively. The RPG projects evolved into changed practice models. The partnerships adopted new norms as standard ways of doing business. They established what they referred to as a culture of collaboration in serving child welfare families affected by parental substance use disorders.
- Successful sustainability required early and substantial discussions among collaborative partners, TA to use evaluation and other information to identify sustainable components and make the case for sustainability to decision-makers and engagement with key stakeholders.

Nearly three-fourths of the major services and activities provided through the RPG Program will be sustained after the grant.

The first cohort of grantees whose accomplishments have been highlighted in this report have laid the groundwork for this additional research. HHS has been deliberate in its efforts to use the evaluation of the next cohort of grantee programs as an opportunity to explore some of the questions posed here as areas of additional research. Building upon the experience of the first wave of RPGs, HHS-funded a national cross-site evaluation for the second wave of RPGs. Grantees are expected to implement evidence-based and trauma-informed services and participate in the cross-site evaluation to determine the impact of these programs on well-being, safety, permanency, and recovery outcomes. Grantees' evaluation plans should include an appropriate comparison group, one that is either randomly assigned or matched on key characteristics.

While awaiting data from the new cross-site evaluation, several important questions remain that should be addressed with the performance monitoring data used for this report. Demographic and performance monitoring data will be uploaded to the National Data Archive on Child Abuse and Neglect (NDACAN). NDACAN acquires data from leading researchers and national data collection efforts and makes these datasets available to the research community for secondary analysis. The following questions can be pursued with findings disseminated broadly to benefit the child welfare and substance abuse treatment fields:

- What are the optimal combinations of intervention, engagement, and retention strategies in terms of improved child welfare and family well-being outcomes?
- What strategies are most strongly associated with challenging problems of racial disproportionality in treatment engagement, retention and success and child well-being?
- What are the relationships between family composition, service access and child removal?
- What engagement and other strategies are associated with stronger linkages with supportive services?

Finally, HHS and the child welfare and substance abuse treatment fields should consider pursuing important issues that cannot be addressed with previous performance monitoring or planned cross-site evaluation data. These issues include:

- Specification of effective targeting, engagement and the proper scale of coordinated, cross-systems efforts
- Specification of services and program components that optimize outcomes
- Relationships between sustained programs and management or collaborative structures, including the extent to which grantees are able to leverage additional resources to benefit program participants and the specific strategies used by grantees in negotiations with state, local, tribal, and private funding sources in redirecting existing resources when innovative methods prove more effective
- Costs and benefits of cross-systems approaches, documented by cost analysis

  Specific topics that the performance monitoring team suggests addressing through publications in refereed journals include:

- Promising program strategies-- a descriptive study of the state of the art represented by grantee efforts to improve family well-being
- An analysis of the interrelationships between adult, child, and family well-being and treatment outcomes
- Additional analyses of outcomes related to specific promising strategies especially outreach and engagement and family drug court approaches. .

During a period of economic uncertainty and working with thousands of the hardest to serve families, the RPG projects improved outcomes while developing lessons and practice changes of direct relevance to many more children and families in the child welfare, treatment and court systems. This report has summarized those lessons and future directions for building on this strong foundation.

ENDNOTES

[1] A second cohort of grantees began their projects in October 2012.

[2] SAMHSA supports the NCSACW through a contract with the Center for Child and Family Futures.

[3] The first cohort's funding stopped at the end of FY2012 but x grantees received a 2-year extension through a second competitive grant award process.

[4] Office of Applied Studies. (2009). The *NSDUH report: Children living with substance-dependent or substance-abusing parents: 2002 to 2007*. Rockville, MD: Substance use and Mental Health Services Administration.

[5] Ibid.

[6] Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who *are the infants in out-of-home care? An epidemiological and developmental snapshot.* Chicago: Chapin Hall at the University of Chicago.

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[25] Voluntary child welfare cases are those referred to community-based or voluntary in-home child protective services; pre-filing cases include those where a dependency petition has been

held in abeyance pending successful completion of voluntary services or the case has been diverted from court jurisdiction in lieu of filing a dependency petition; and differential or alternative response cases include the provision of voluntary services for families, which may include closed child welfare cases.

[26] Past month nonmedical use of prescription-type drugs (pain relievers, tranquilizers, stimulants, and sedatives) by persons aged 12 or older rose from 6.2 million (2.5 percent) in 2008 to 7.0 million (2.7 percent) in 2010. In addition, the number of individuals with pain reliever dependence or abuse increased from 1.5 million to 1.9 million. (The 2010 numbers and percentages are similar to those in 2009.) Substance use and Mental Health Services Administration (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* (Office of Applied Studies, NSDUH Series H-41, HHS Publication No. SMA 11-4658. Rockville, MD.

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[28] All races exclude children of Hispanic origin; Asian includes Native Hawaiian/Other Pacific Islander.

[29] Where comparable data were available.

[30] Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. http://cwoutcomes.acf.hhs.gov/data/overview; Accessed April 3, 2013. Of all children who were victims of a substantiated/indicated maltreatment allegation during the first 6 months of the most recent fiscal year, percentage who were victims of another substantiated/indicated maltreatment allegation within 6 months following that maltreatment incident. This occurrence of maltreatment within 6 months (180 days) of the first occurrence is usually referred to as "recurrence."

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[33] Data for program year five are excluded due to small number of foster care discharges to permanency (n=8).

[34] Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. http://www.cwoutcomes.acf.hhs.gov/data/overview; Accessed March 27, 2012.

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[36] Grantees used nearly 50 different strategies to assess well-being. These findings are summarized in Reports to Congress and in grantees' annual reports to the Children's Bureau. Additional information can be found in the Reports to Congress available at http://www.cffutures.org/projects/rpg.

[37] Analysis for substance abuse prevention and education was limited to children aged 5 and older; analysis for substance abuse treatment was limited to children aged 12 and older. All supportive service data may change over time as the assessment for and provision of supportive services may occur at various points over the course of an individual's involvement in the RPG program. Further, a child may have entered the grantee's program close to the reporting period cutoff date and information on receipt of services was not yet available; this information will be added in a subsequent data submission.

[38] Includes methamphetamine, amphetamines or other stimulants; 98.6 percent is methamphetamine

[39] Includes hallucinogens, benzodiazepines, barbiturates, other tranquilizers and sedatives and other drugs

[40] Only 2010 indicators in the Treatment Episode Data Set (TEDS) were available for Arizona and Illinois. Data for 2011 were available in each of the other 26 states.

[41] Treatment Episode Data Set – Accessed May 6, 2013 at SAMHSA Drug and Alcohol Services Information System (DASIS) http://wwwdasis.samhsa.gov/webt/NewMapv1.htm. Data represent 1,424,483 treatment admissions for 28 states in which RPGs are located. Aggregated state data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants. Methamphetamine includes amphetamine and other stimulants.

[42] Excluded adults discharged from treatment, but whose discharge status was unknown. Numbers are based on total discharges; an adult may have multiple discharges from treatment. Transferred to another treatment program/facility and known to report is considered a positive treatment outcome per Federal TEDS treatment discharge reporting. Dropped out included transferred to another facility but did not report. Other discharge status included terminated by action of facility, incarcerated, death and other reason somewhat outside of client's control.

[43] Since 85.5 percent of all discharges were related to the first substance abuse treatment episode for adults in the RPG program, the median length of stay in treatment is computed on the basis of 8,725 first discharges with valid date elements.

[44] State of Arizona

[45] Though the NOMs operational definition for reduction in substance use focuses on abstinence and does not directly align with the RPG indicator measure, it still provides instructive context for understanding grantees' performance.

[46] NOMS percent change is calculated as ((Discharge% - Intake%) / Intake%) * 100).

[47] The results exclude the substantial number of adults who reported no use in the 30 days prior to treatment intake and discharge. The large percentage of adults reporting no recent substance use could be due to factors such as clients having already been under court supervision and undergoing regular drug testing, parents' unwillingness to disclose use for fear of repercussions from child welfare or other adverse consequences, or other factors related to type of drug and treatment modality.

[48] Percent change is calculated by subtracting "old" data from "new" data, dividing that result by old data and multiplying it by 100. For example, [(25.1-13.1)/13.1] x 100 = 91.6 percent change.

[49] The data necessary to compute reduced criminal behavior are available for 5,195 adults, 29.2 percent of the 17,820 adults served by the 53 regional partnerships over the course of the initial five-year grant period. The extent to which these results generalize to the entire population of adults served by the RPG Program is unknown.

[50] The RPG measure differs somewhat from NOMs in that the percentage of clients with no arrests in the 30 days prior to treatment admission and discharge are not included in the calculation. However, these data are available for RPG adults and are provided as additional contextual data. The national data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants.

[51] The CCI was developed by Children and Family Futures, Inc. and has been tested for reliability and internal consistency for measuring improvements in these practices over time (Drabble, L., Pathways to collaboration: Exploring values and collaborative practice between child welfare and substance abuse treatment fields. *Child Maltreatment*, 2007; 12:31-42). To date, the HHS-funded National Center on Substance Abuse and Child Welfare has used the CCI with approximately 38 states, 250 counties, 300 local level entities, and 9 tribes.

[52] For the interim and final CCI administration, an average of 43 percent of respondents was front-line staff, while 37 percent were administrators, managers, or supervisors.

[53] There is no uniform or standardized definition for what it means for a family to have active involvement in case planning. Grantees have the flexibility to define and operationalize "active involvement in case planning" at the local level, as they deem appropriate.

[54] Percentages do not add to 100 because more than one topic can be covered in a given training.

[55] Johnson, N., Oliff, P. & Williams, E. (February 9, 2011). *An Update on State Budget Cuts.* Washington, DC: Center on Budget and Policy Priorities.

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[57] For information on four key stages of collaboration, see Gardner, S. (1998). *Beyond Collaboration to Results: Hard Choices in the Future of Services for Children and Families.* Tucson, AZ: Arizona Prevention Research Center.

[58] These included Children Affected by Methamphetamine (SAMHSA), Pregnant and Postpartum Women's treatment programs (SAMHSA), Access to Recovery (SAMHSA), Abandoned Infants Assistance: Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS (ACF), Initiative to Reduce Long-term Foster Care (ACF), Trauma Informed Child Welfare Systems (SAMHSA), the Maternal, Infant, and Early Childhood Home Visiting program (HRSA), Fetal Alcohol Syndrome Disorders Training Grant (HRSA), and Family Drug Court Programs (OJJDP).

APPENDIX

Regional Partnership Grantees by Program Funding Option (Listed Alphabetically by State)*			
Grantee	**City**	**State**	**Congressional District Served by Project**
Program Option 1: Three-Year Projects $1 million Annual Award			
Denver Department of Human Services	Denver	CO	1
North Range Behavioral Health Center[9]	Fort Collins	CO	4
Pierce County Alliance	Tacoma	WA	6
Program Option 2: Five-Year Projects $1 million Annual Award			
County of Santa Clara, Social Services Agency	San Jose	CA	10, 13-16
SHIELDS for Families, Inc.	Los Angeles	CA	37
Idaho Department of Health and Welfare	Boise	ID	1, 2
Children's Research Triangle (CRT)	Chicago	IL	12
Kentucky River Community Care, Inc.	Jackson	KY	5
One Hope United - Hudelson Region	St. Louis	MO	Statewide
Multnomah County	Portland	OR	3
State of Nevada	Carson City	NV	1, 3
Child and Family Tennessee	Knoxville	TN	2
Program Option 3: Three-Year Projects $500,000 Annual Award			
State of Arizona	Phoenix	AZ	4
Butte County Department of Employment and Social Services	Oroville	CA	1, 2

[9] Former lead agency was Island Grove Regional Treatment Center, Inc.

Regional Partnership Grantees by Program Funding Option (Listed Alphabetically by State)*			
Grantee	**City**	**State**	**Congressional District Served by Project**
Supreme Court of Georgia	Atlanta	GA	3, 9, 13
Omaha Nation Community Response Team (ONCRT) ☼	Walthill	NE	1
University of Rochester	Rochester	NY	28
County of Lucas	Toledo	OH	9
Program Option 4: Five-Year Projects $500,000 Annual Award			
Cook Inlet Tribal Council, Inc. ☼	Anchorage	AK	1
Center Point, Inc.	San Rafael	CA	6
County of San Diego, Health and Human Services Agency, Child Welfare Services	San Diego	CA	50-52
County of Santa Cruz, Health Services Agency, Alcohol and Drug Program	Santa Cruz	CA	17
Mendocino County Health and Human Service Agency	Ukiah	CA	1
Sacramento Department of Health and Human Services	Sacramento	CA	3, 5
WestCare California, Inc.	Fresno	CA	9
Clarity Counseling P.C.10	Dolores	CO	NM-3
AspenPointe Health Network 11	Colorado Springs	CO	5
Hillsborough County Board of Commissioners	Tampa	FL	11

[10] Although Clarity Counseling is officially located in Dolores, Colorado, its regional partnership program operated and served families in New Mexico.

[11] Lead agency was formerly known as Connect Care, Inc.

Regional Partnership Grantees by Program Funding Option (Listed Alphabetically by State)*			
Grantee	**City**	**State**	**Congressional District Served by Project**
Juvenile Justice Fund	Atlanta	GA	5
Judicial Branch State of Iowa	Des Moines	IA	Statewide
Upper Des Moines Opportunity, Inc.	Graettinger	IA	5
Kansas Department of Social and Rehabilitation Services	Topeka	KS	Statewide
Kentucky Department for Community Based Services	Frankfort	KY	Statewide
Massachusetts Department of Public Health	Boston	MA	1, 2
White Earth Band of Chippewa ☼	White Earth	MN	7
St. Patrick Center	St. Louis	MO	1
Apsaalooke Nation Housing Authority (ANHA) ☼	Crow Agency	MT	1
Second Chance Homes[12]	Billings	MT	1
Westchester County	White Plains	NY	18
North Carolina Department of Health and Human Services	Raleigh	NC	7
Butler County Children Services (BCCS)	Hamilton	OH	8
Choctaw Nation of Oklahoma ☼	Durant	OK	2
Oklahoma Department of Mental Health and Substance Abuse Services	Oklahoma City	OK	5
Baker County/Northeast Oregon Collaborative	Baker City	OR	2

[12] Former lead agency was The Family Tree Center - Billings Exchange Clubs' CAP Center.

Regional Partnership Grantees by Program Funding Option (Listed Alphabetically by State)*			
Grantee	**City**	**State**	**Congressional District Served by Project**
Klamath Tribes ☼	Chiloquin	OR	2
OnTrack, Inc.	Medford	OR	2
Children's Friend and Service	Providence	RI	1, 2
Tennessee Department of Mental Health	Nashville	TN	4, 6
Aliviane, Inc.	El Paso	TX	16
Houston Council on Alcoholism and Drug Abuse	Houston	TX	7
Travis County	Austin	TX	21
Lund Family Center	Burlington	VT	1
Wisconsin Department of Health and Family Services	Madison	WI	Statewide

* The city represents the location of the grant's lead agency. However, the lead agency location was not always the same as where the partnership implemented its program and provided services. The majority of grantees provided services to families in multiple counties or regions throughout a state.

☼ Tribal grantee

GRANTEE SITE SUMMARIES

The following site summaries cover the 44 grantees that have completed RPG-funded work and submitted Final Reports. Site summaries are based on various sources including: Grantee Semi-Annual Progress Reports, Grantee Final Reports, Semi-Annual Data Uploads, and Performance Management Liaison (PML) reviews.

Name of Lead Agency	**Denver Department of Human Services (DDHS)**
Location	**Denver, CO**
Title of Project	**Denver Entire Family Focused Effective Comprehensive Treatment (Denver EFFECT): Family-Centered Solution to Improving Outcomes for Children at Risk of or in Out-of-Home Placement as a Result of Parental/Caretaker Substance Abuse**
Program Option	RPG 3-Year Grant (2007-2010); $1,000,000 annually
Geographic Area and Congressional District Served	City of Denver Congressional District 1
Brief Program Description	Through a partnership between DDHS, Arapahoe House, Addiction Research Treatment Services and Treatment Accountability for Safer Communities, Denver EFFECT constructed a family-centered system of care to improve the safety, well-being and permanency of children living within the City and County of Denver who are at risk of or in out-of-home placement as a result of a parent's or other primary caregiver's substance abuse. Denver EFFECT embodies a fundamental philosophical shift in treating the entire family, rather than just the individual involved in substance abuse treatment or with an open case in child welfare. The program's main components centered on family therapy and enhanced clinical case management through substance abuse treatment providers and required that at least one supportive family member participated to some degree in treatment with the identified client.
Target Population	**Denver EFFECT targeted:** • One or more substance dependent caregiver in need of treatment, with priority given to families in which methamphetamine is the primary substance of abuse Children who are currently in or at risk of out-of-home placement • Families experiencing a complexity of co-occurring problems (e.g., mental health, domestic violence, children with mental health, development, substance abuse or other problems)
Participants Served	Children: 245 Adults: 344 Families: 109

Major Goals	**Major program goals included:** • Providing comprehensive family-centered services that recognize individual needs and build on family strengths and protective factors to achieve safety, permanency and well-being for children who are at risk of or in out-of-home placement as a result of substance abuse, with a special focus on methamphetamine • Integrating the child welfare, substance abuse treatment and court systems into a cohesive infrastructure to strengthen and coordinate family-centered services for families in which children are at risk of or in out-of-home placement as a result of substance abuse
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Services **Mental Health and Trauma** • Mental Health Services & Psychiatric Care • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Engagement/Involvement of Fathers** • Targeted Outreach to Fathers • Specialized Program or Services for Fathers **Screening and Assessment – Child Welfare and Other Children's Issues** • Prenatal Exposure • Specialized Child Screening and Assessment – Socio/Emotional, Behavioral, Substance Use, Developmental **Housing Services** • Housing Assistance **Children's Services** • Early Intervention Services • Trauma Services • Developmental Services • Therapeutic Services

Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Bilingual Substance Abuse Treatment Provider(s) **Courts** • Family Drug Court • Juvenile Justice Agency **Criminal Justice, Law Enforcement, Legal and Related Organizations** • State Department of Corrections (including State probation and prisons) • County Corrections (including county/local probation and jails) • Local Law Enforcement • Attorney(s) General • Legal Services/Client Advocacy **Other Community and Child and Family Services** • Home Visiting Agency or Services Provider • Church or Faith-based Organization • Domestic Violence Services Provider/Agency • Peer/Parent Mentor Group or Network • Foundation **Housing** • State/County Housing Agency • Housing/Homeless Services Provider **Mental Health and Health Services** • Regional/County Mental Health Agency • Mental Health Services Provider • County Maternal and Child Health • County Public Health Agency – Other Public Health • Adult Health Services Provider/Hospital • Children's Health Services Provider/Hospital **Education** • County/Regional School District • Individual School(s) • Early Childhood Services/Education Provider

	• Parenting Education/Services Provider **Employment** • State/County Employment Agency • State/County Temporary Assistance for Needy Families or Welfare Office **Other Evaluation and Training** • Evaluator (University-affiliated or other)
Evaluation Design and Comparison Group Type	Quasi-experimental Historical, Matched Population-Level
Performance Indicators	**Recovery** Timely Access to Substance Abuse Treatment: On average, Denver EFFECT clients entered substance abuse treatment within 25 days after they entered the RPG program, compared to 69 days for comparison group adults. Retention in Substance Abuse Treatment: Denver EFFECT clients remained in substance abuse treatment for an average of 200 days, compared to 102 days for comparison group adults. Reduction in Substance Use: The percentage of clients reporting alcohol, marijuana, methamphetamine, or cocaine use in the past 30 days significantly decreased from substance abuse treatment to discharge. There was also a significant decrease in the number of days clients used alcohol and marijuana. While there was a decrease in the number of days clients used methamphetamine and cocaine, these findings were not statistically significant. **Adult Well-Being** Mental Health Functioning: Denver EFFECT clients showed significant decreases in client-reported trouble due to family, psychological and emotional problems, as well as a decreased desire for treatment for these problems from baseline and discharge. Clients also reported a significant decrease in the number of days they experienced depression or anxiety as well as a decrease in their overall experience of psychological or emotional problems.
Sustainability Status	The Denver EFFECT program was sustained close to its existing model. Onsite childcare at one of the treatment provider sites was the only component dropped.
Project	Nachshon Zohari

Director and Contact Information	Denver Department of Human Services 1200 Federal Blvd. Denver, CO 80204 (720) 944-3177 nachshon.zohari@denvergov.org
Project Director and Contact Information	Brianna Gass Colorado Social Research Associates 3530 W. Lehigh Ave. Denver, CO 80236 (303) 412-3994 bgass@ahinc.org

Name of Lead Agency	**North Range Behavioral Health Center**
Location	**Fort Collins, CO**
Title of Project	**Northeastern Colorado Child Welfare Project (NRBH)**
Program Option	RPG 3-Year Grant; $1,000,000 annually
Geographic Area and Congressional District Served	Weld and Larimer County Congressional District 4
Brief Program Description	NRBH provided integrated substance abuse, mental health and community services to children and families in Larimer and Weld Counties who were involved with the child welfare system, particularly those involved with methamphetamine. The project focused on increasing the safety, well-being and permanency of at-risk children by providing a continuum of integrated services to those children, their parents and caregivers and their families' support system. Two new Family Treatment Courts (FTCs) opened (one each of the counties) and one pre-existing FTC in Weld County was expanded to include additional components.
Target Population	**The project targeted:** Families that met the following criteria:

	• Children and families who have entered the Weld or Larimer County child welfare system and showed evidence of methamphetamine use by parent or caretaker • Families of individuals who have entered into a drug court in the 8th or 19th Judicial District
Participants Served	Children: 197 Adults: 149 Families: 92
Major Goals	**Major program goals included:** • Addressing parental substance abuse more effectively • Addressing the needs of children so that they can become healthy, successful adults, despite parental substance abuse • Promoting cross-agencies collaboration to increase the quality, appropriateness and effectiveness of services for families involved with substance abuse and the child welfare systems
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Services **Mental Health and Trauma** • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Substance Abuse Treatment for Adults** • Intensive Outpatient – Matrix Model • Aftercare/Continuing Care • Family-Centered Treatment • New Family Treatment Drug Court **Housing Services** • Housing Support Services • Housing Assistance • Transitional/Short-Term Housing **Children's Services** • Early Intervention Services • Developmental Services • Therapeutic Services

	• Trauma Services **Engagement/Involvement of Fathers** • Targeted Outreach to Fathers • Specialized Program or Services for Fathers **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Therapy Strategies – Motivational Interviewing, Motivational Enhancement Therapy, Contingency Management • Co-located Staff • Screen/Assess/Brief Interventions • Peer/Parent Mentor
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Regional/County Substance Abuse Treatment Agency **Other Evaluation and Training** • Evaluator (University-affiliated or other) • Consultant/Training **Courts** • Family Treatment Drug Court **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Legal Services/Client Advocacy **Mental Health** • Regional/County Mental Health Agency
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	**Safety** Average Length of Stay in Foster Care: Among those children placed in foster care, the comparison group spent more time in foster care (11.49 months) than the FTC group (8.80 months). Parenting: Results indicate that overall parental capabilities, measured using the North Carolina Family Assessment Scale (NCFAS) and assessed by caseworkers, improved significantly. Comparison of the intake and

	discharge ratings on overall parental capabilities reveals that 75.0 percent of the FTC families and 67.0 percent of the comparison families were rated as having a problem (mild, moderate, or serious) at intake, whereas only 10.0 percent of the families were rated as having a problem at discharge. **Recovery** Retention in Substance Abuse Treatment: FTC parents averaged more days per treatment episode than the comparison group. **Adult Well-Being** Education and Employment: The percentage of clients reporting employment increased from 37.2 percent to 56.3 percent from program intake to discharge. Mental Health Functioning: The percentage of clients reporting overall symptom severity, anxiety symptoms and depressive issues decreased significantly from intake to discharge for the FTC treatment group. On the overall symptom severity item, the percentage of clients experiencing problems decreased from 71.0 percent to 35.0 percent, demonstrating a 50.7 percent change. Items were assessed using the Colorado Client Assessment Record (CCAR).
Sustainability Status	Both FTCs continued beyond grant funding by using existing local resources.
Project Director and Contact Information	Kendall P. Alexander Island Grove Regional Treatment Center, Inc. 1140 M St. Greeley, CO 80631 (970) 313-1186 kalexander@islandgrovecenter.org
Project Evaluator and Contact Information	Robbyn Wacker, PhD University of Northern Colorado 501 20 St. Greeley, CO 80639 (970) 351-1582 robbyn.wacker@unco.edu

Name of Lead Agency	**Pierce County Alliance**
Location	**Tacoma, WA**

Title of Project	Methamphetamine Family Services (MFS)
Program Option	RPG 3-Year Grant; $1,000,000 annually
Geographic Area and Congressional District Served	Pierce County Congressional District 6
Brief Program Description	Since its inception in 1972, Pierce County Alliance has served the citizens of Washington State in a variety of ways. For example, Methamphetamine Family Services (MFS), a court-mandated treatment program, treated users of methamphetamine or other illicit drugs. MFS was designed specifically for individuals whose child custody rights were at risk due, at least in part, to their drug use. Additionally, MFS worked to assist in successful recovery so that parents with substance use disorders could regain custody of their children. The program was built on an outpatient model of chemical dependency treatment which moved a client through three stages, or phases, of recovery. Abstinence was key and monitored throughout the program by a random system of forensic alcohol or drug testing.
Target Population	**The project targeted:** • Families with children in or at risk of being in out-of-home placement as a result of a parent‘s or caregiver's methamphetamine or other substance dependency in Region V of Washington State
Participants Served	Children: 210 Adults: 118 Families: 100
Major Goals	**Major program goals included:** • Improving the well-being and permanency outcomes of children in or at risk of out-of-home placement as a result of a parent’s or caregiver’s alcohol and other drug dependency • Reducing the number of out-of-home placements and reunification rates • Reducing the recidivism of drug use by parents or caregivers after treatment has been completed
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing

	• Wraparound/Intensive In-Home Services **Mental Health and Trauma** • Mental Health Services • Trauma-Informed Services **Substance Abuse Treatment for Adults** • Aftercare/Continuing Care • Family-Centered Treatment • Enhanced Family Treatment Drug Court **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Therapy Strategies – Moral Reconation Therapy **Children's Services** • Early Intervention Services • Developmental Services • Therapeutic Services • Trauma Services **Housing Services** • Housing Supportive Services • Housing Assistance
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/County Child Welfare Agency • Child Welfare Services Provider **Substance Abuse** • Substance Abuse Treatment Provider **Courts** • Family Treatment Drug Court • Juvenile Justice Agency • Court Appointed Special Advocates (CASA) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Attorney General • Legal Services/Client Advocacy **Other Community and Child and Family Services** • Home Visiting Agency or Services Provider

	Other Evaluation and Training • Evaluator (University-affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Historical, Aggregate
Performance Indicators	**Safety and Permanency** Foster Care Re-entries: Among children reunified, none re-entered foster care following reunification. **Recovery** Timely Access to Treatment: On average, RPG adults entered substance abuse treatment within nine days after they entered the RPG program. Treatment Retention: Among those discharged from substance abuse treatment, 46.7 percent completed treatment. Overall, the median length of stay in treatment was 394 days. Reduced Substance Use: Among RPG adults who reported any substance use in the past 30 days at treatment admission, the percentage who reported reductions in use at discharge was between 71.4 percent and 88.6 percent, depending on the substance.
Sustainability Status	At the end of the three-year grant, most of the key innovations implemented were sustained. Pierce County Alliance and the other partners will continue to use the online evaluation system so that outcomes reports can be regularly updated.
Project Director and Contact Information	Terree Schmidt-Whelan, PhD Pierce County Alliance 510 Tacoma Ave. South Tacoma, WA 98402 (253) 572-4750 schmidtt@p-c-a.org
Project Evaluator and Contact Information	Lisa Daheim Pierce County Alliance 510 Tacoma Ave. South Tacoma, WA 98402 (253) 572-4750 daheimlm@p-c-a.org

Name of Lead Agency	**County of Santa Clara, Social Services Agency**
Location	**San Jose, CA**
Title of Project	**Santa Clara County Family Wellness Court (FWC)**
Program Option	RPG 5-Year Grant; $1,000,000 annually
Geographic Area and Congressional District Served	County of Santa Clara Congressional District 10, 13-16
Brief Program Description	The Santa Clara County Family Wellness Court (FWC) for Infants and Toddlers was created to enhance and expand services for pregnant women and women with children birth to three who are risk of losing their children because of their addiction to methamphetamine or other drugs and documented child abuse or neglect. FWC is an enhancement of the model being used by the Santa Clara County Dependency Drug Treatment Court (DDTC), a previously implemented Drug Treatment Court for families in child welfare. While the program was initially designed to serve pregnant women and women with young children, services to fathers and the entire family were introduced in the second year due to the number of fathers and couples being referred to the court. The FWC was comprised of a comprehensive drug court team that included a dedicated judge, child welfare staff, substance abuse treatment staff, mental health staff for both parents and children, attorneys for parents, children and the county, CASAs, Mentor Parents, children's specialists, domestic violence services staff and public health nurses. Hallmarks of the model include: • Mentor Parents • Children's screening, assessment and intervention services • Home visiting services • Intensive case management for the family • Evidence-based parenting programs • Fatherhood engagement and services • Family-focused services • Trauma informed court 501C-3 created to provide basic essentials to families, such a diapers, clothing and temporary assistance with basic needs

Target Population	**The project targeted:** Pregnant women and parents with children 0 to 3, whose abuse of methamphetamine and other substances have placed their children in or at risk of out of home placement.
Participants Served	Children: 431 Adults: 378 Families: 262
Major Goals	**Major program goals included:** The grantee identified the following goals for the Family Wellness Court program: • Early identification of and intervention for pregnant women and mothers/parents • Rapid engagement and successful retention in treatment and care • Reduction in subsequent births to mothers who are abusing methamphetamine • Early identification of and intervention for developmental delays, disabilities and concerns for children 0-3 whose parents come before the DDTC. • The creation of a comprehensive System of Care across all systems serving children who are in or at risk of out-of-home placement as a result of parents' methamphetamine and other substance abuse.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Comprehensive Services **Parenting/Family Strengthening** • Standard and Enhanced Parenting Skills Training/Education • Evidence-Based Parenting or Family Strengthening Program – Triple P, Nurturing Fathers, Touchpoints **Visitation** • Supervised Visitation • Supportive Supervised Visitation **Mental Health and Trauma Services for Adults** • Trauma-Informed Services – Seeking Safety, Trauma-Focused Cognitive-Behavioral Therapy (TC-CBT), Trauma Services for Men

Substance Abuse Treatment for Adults

- Long-Term Residential/Inpatient (more than 30 days)
- Residential/Inpatient Treatment – Specialized for Parents with Children – Matrix Model
- Non-Intensive Outpatient or Other Step-Down

Specialized Outreach, Engagement and Retention

- Cognitive Behavioral Strategies – Motivational Interviewing, Contingency Management
- Peer/Parent Mentor

Family-Centered Substance Abuse Treatment

Screening and Assessment – Child Welfare and Other Children's Issues

- Screening and Assessment for Child Welfare Issues
- Screening and Assessment for Trauma
- Other Specialized Child Screening and Assessment – Developmental, Behavioral/Socio-Emotional, Mental Health/Psychological, Educational

Screening and Assessment – Substance Use and Other Adult Issues

- Screening and Assessment for Substance Use Disorders
- Other Specialized Adult Screening and Assessment – Mental Health/Co-Occurring Disorders, Trauma/Domestic Violence, Parenting

Children's Services

- Early Intervention and Developmental Services
- Cross-Systems/Interagency Collaboration
- Clinical and Program Training
- Cross-systems Policies and Procedures
- Regular Joint Case Staffing Meetings
- Co-location of Staff
- Cross-systems Information Sharing and Data Analysis
- Partner Meetings

Housing Services

- Housing Support Services
- Transitional, Interim or Temporary Short-Term Housing
- Permanent Supportive Housing
- Family Treatment Drug Court

	Other • Medical and Dental Care for Children and Parents
Partner Agencies and Organizations	**Child Welfare** • County Child Welfare Agency **Substance Abuse** • County Substance Abuse Agency • Substance Abuse Treatment Agency/Providers **Courts** • Family Treatment Drug Court (FTDC) • Other Dependency Court • Court Appointed Special Advocate (CASA) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Attorneys General • Attorneys • Legal Services/Client Advocacy • Victim Witness **Mental Health and Health Services** • County Mental Health Agency • Mental Health Services Provider(s) • County Public Health • Adult Health Services Provider/Hospital • Children's Health Provider/Hospital • Dental Services Provider • Children's Regional Centers **Housing** • State/County Housing Agency • Housing/Homeless Services Provider **Education** • Early Childhood Services/ Education Provider • Early Childhood Council/Coalition • Parenting Education/Services Provider **Employment**

	• County Temporary Assistance for Needy Families (TANF) or Welfare Office • Employment Services Provider **Other Community and Child and Family Services** **Home Visiting agency/Services Provider** • Other Child Family Services Provider • Church/Faith-based Org • Domestic Violence Services Provider/Agency • Peer/ Parent/Mentor Group or Network • Other Community Stakeholder Group **Other Evaluation and Training** • Evaluator (University or Affiliated or Other) • Consultant/Training • University Child Welfare Research Department
Evaluation Design and Comparison Group Type	Quasi-experimental Historical Usual Child Welfare/Substance Abuse Services
Performance Indicators	**Safety** • Children remained at home (never were removed) (8% vs. 1% in the comparison group) **Permanency** • Children were reunified with at least one parent (74% vs. 44% in the comparison group) **Recovery** • Received access to timely substance abuse assessment (45 days vs. 160 days for the comparison group) • Received access to timely substance abuse treatment (65 days vs. 245 days for the comparison group) • Decreased substance use at program entry (58%) to the most recent follow-up (20%) **Well-Being** • Though comprehensive services to children and families continues to be one of the hallmarks of the program, tracking and reporting on services data (e.g. children's screening and assessment, intervention

	services, housing, transportation, dental services and other supportive services) proved burdensome for those agencies providing the services.
Sustainability Status	Despite ongoing and significant budget problems throughout the five years of this grant, in Year five all partners committed to continuing all programs and services that were provided to the Family Wellness Court (FWC) during the RPG grant. The only program without an additional source of funding was the Mentor Parents Program. The Dependency Advocacy Center (DAC) and the FWC previously received a Bureau of Justice Administration grant that partially funded four positions part-time. All partners made a joint presentation to the Board of Supervisors advocating for funding for this program. The County Board of Supervisors voted to approve additional monies to support transitioning the four part-time Mentor Parents to full-time mentors with employee benefits. The board also approved funding for a much needed part-time clinician to support the Mentor Parents around issues relating to secondary trauma and client engagement. The FWC model was then integrated into the Santa Clara County Dependency Drug Treatment Court (DDTC). This move ensured that all families coming before the DDTC received the comprehensive array of services and team approach developed through the FWC, while retaining specialty services for children birth to three.
Project Director and Contact Information	Connie Vega Connie.Vega@ssa.sccgov.org
Project Evaluator and Contact Information	Shari Golan, Ph.D. Program Manager, School Partnerships SRI International 333 Ravenswood Avenue, BS-110 Menlo Park, CA 94025 (650)859-4007 (650)859-5258 shari.golan@sri.com

Name of Lead Agency	**SHIELDS for Families, Inc.**
Location	**Los Angeles, CA**
Title of Project	**TAMAR Village Program**

Program Option	RPG 5-Year Grant; $1,000,000 annually
Geographic Area and **Congressional District Served**	South Central Los Angeles Congressional District 37
Brief Program Description	SHIELDS for Families' Tamar Village Program was implemented to provide comprehensive substance abuse treatment services to families involved with the child welfare and criminal justice systems. Tamar Village is a unique model in which comprehensive family-centered treatment, follow-up and related social services are provided onsite in an apartment complex. SHIELDS for Families, with the Los Angeles County Department of Children and Family Services, the Los Angeles Sheriff's Department, the Los Angeles County Public Defender's Office, the Los Angeles County Alcohol and Drug Program Administration and the Corporation for Supportive Housing, ensured that the population with the greatest need is targeted and enhances the opportunities for families to maintain custody of their children while in treatment or, if in foster care, to have them returned as soon as possible. The overall goal of the Tamar Village Program was to provide a comprehensive family-centered treatment program that would achieve safety, permanency and well-being for the children and families served and enhance the service capacity in the community.
Target Population	**The project targeted:** • Pregnant and substance abusing mothers who were involved with the child welfare system and criminal justice system in South Los Angeles
Participants Served	Children: 92 Adults: 109 Families: 109
Major Goals	**Major program goals included:** • Protecting children from abuse and neglect • Improving permanency and stability in the child(ren)'s living situations • Ensuring that the child(ren) have opportunities for healthy social and emotional development • Ensuring that the child(ren)'s educational, physical and mental health needs are met • Enhancing the families' capacity to provide for children's needs

	• Increasing the region's ability to address parental or caretaker substance abuse and its affect on children
Key Major Program Services	**Case Management and In-Home Services** • Intensive Case Management • Family Group Decision-Making • Wraparound/Intensive In-Home Services **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Triple P **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Engagement/Involvement of Fathers** • Targeted Outreach • Specialized Program or Services for Fathers **Family-Centered Substance Abuse Treatment Services** **Housing Services** • Housing Support Services • Transitional/Temporary Short-Term Housing **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing • Screening, Brief Intervention and Referral to Treatment (SBIRT) • Co-location of Staff
Partner Agencies and Organizations	**Child Welfare** • Los Angeles County, Department of Children and Family Services (DCFS) **Substance Abuse** • Los Angeles County Substance Abuse Prevention and Control (SAPC) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Los Angeles County, Sheriff's Department • Community Transition Unit (CTU) • Public Defender
Evaluation	Quasi-experimental

Design and Comparison Group Type	Same-Time, Matched Population-Level
Performance Indicators	**Permanency** Children Remain at Home: Findings indicate that 50.0 percent of the women who engaged in treatment with their children were able to maintain custody throughout treatment. Reunification: Of the children in foster care, 16.7 percent were reunified with a parent or caretaker in less than 12 months, 48.0 percent of the children in foster care were reunified more than 12 months from the date of reunification. **Child Well-Being** Child Supportive Services: All children enrolled in the RPG program were assessed for developmental, mental health, primary pediatric care, substance abuse prevention and education and educational services. Children in the comparison group also received screening and assessment; however, at much lower rates. Of those in the comparison group, 23.0 percent were assessed for developmental services, mental health services and primary pediatric health care needs. Twenty-two percent were assessed for educational services.
Sustainability Status	The TAMAR Village Program was able to continue on a smaller scale past the award period. Program slots were reduced from 30 to 15 and the target population for TAMAR continued to be clients with child welfare and criminal justice issues. Assessments in the local women's jail were also able to continue. Monies from the Los Angeles County, Substance Abuse Prevention and Control Office and First Five L.A. were allocated to continue TAMAR Village. Additionally, SHIELDS for Families with the assistance from Community One Consulting and with funding from The James Irvine Foundation, developed a Family Centered Treatment Replication Model manual. SHIELDS staff has trained programs across California on this model and have presented the model at many national conferences. These presentations have included a section on implementing the Family Centered Treatment Model with families who have a criminal justice history and a child abuse history.
Project Director and Contact Information	Kathryn Icenhower, Project Director Shields for Families, Inc. 12714 S. Avalon Blvd., Ste 300 Los Angeles, CA 90061 (323) 242-500 kicenhower@shieldsforfamilies.org

Project Evaluator and Contact Information	Denna Sanchez, Evaluator California State University, Dominguez Hills dsanchez@csudh.edu

Name of Lead Agency	**Idaho Department of Health and Welfare**
Location	**Boise, ID**
Title of Project	**Idaho Department of Health and Welfare** **Improving Positive Outcomes for Children through Family Drug Court**
Program Option	RPG 5-Year Grant; $1,000,000 annually
Geographic Area and Congressional District Served	Ada County Congressional District 1 and 2
Brief Program Description	**Objective Are:** • Develop and Implement two new Family Drug Courts - one in Pocatello and one in Boise • Further develop system collaborations and improvements with project stakeholders who include Idaho Single State Authority for Substance Abuse, the Idaho Child Protection program, the Idaho Mental Health program, the Idaho Supreme Court, Road to Recovery a not-for-profit treatment provider, the Idaho State University and the Idaho Statewide Child Protection/Court Improvement Committee • Expand evidence-based practice substance abuse treatment programs for families served under the project • Evaluate the program for further expansion in other areas of the State of Idaho • In reaching the goals and objectives of this project, we anticipate serving 65 families each year
Target Population	**The project targeted:**

	• Children who are in an out-of-home placement, in Idaho's Regions four and six, due to methamphetamine or other substance abuse by a parent/caretaker.
Participants Served	Children: 284 Adults: 173 Families: 131
Major Goals	**Major program goals included:** • Enhance the well-being of children receiving services or taking part in activities conducted with funds provided under the grant; • Lead to safety and permanence for such children, and • Decrease the number of out-of-home placements for children, or the number of children who are at risk of being placed in an out-of-home placement, in the partnership region.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing **Parenting/Family Strengthening** • Evidence-Based Parenting or Family Strengthening Program - Strengthening Families Program **Visitation Services** • Supportive Supervised Visitation **Substance Abuse Treatment for Adults** • Intensive Outpatient • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies - Motivational Interviewing/Moral Recognition Therapy • Peer/Parent Mentor • Co-located of Staff **Substance Abuse Prevention Services** • Prevention Education • Alternative Activities • Community-Based Process **Screening and Assessment – Child Welfare and Other Children's**

	Issues • Screening and Assessment for Child Welfare Issues • Other Specialized Child Screening and Assessment – Developmental, Mental Health/Psychological **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment **Children's Services** • Early Intervention **Cross-Systems/Interagency Collaboration** • Clinical and Program Training • Cross-systems Policies and Procedures • Regular Joint Case Staffing Meetings • Co-location of Staff • Cross-systems Information Sharing and Data Analysis • Partner Meetings
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/ County Child Welfare Agency **Substance Abuse** • State Substance Abuse Agency • Substance Abuse Treatment Agency/Provider(s) **Courts** • Family Treatment Drug Court (FTDC) • Office State Courts Admin • Court Appointed Special Advocate (CASA) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • State Corrections • Drug Endangered Children (DEC) • Legal Services/Client Advocacy **Health Services** • Regional/ County Mental Health Agency • Mental Health Services Providers

	Housing • State/County Housing Agency • Housing/Homeless Services Provider **Education** • Early Childhood Council/Coalition • Parenting Education /Services Provider **Employment** • State/County Employment Agency • State/ County Temporary Assistance for Needy Families (TANF) or Welfare Office • Employment Services Provider **Other Community and Child and Family Services** • Home Visiting Agency/ Services Provider • Other Child/ Family Services Provider • Church/faith-based Org **Domestic Violence Services Provider** **Other Evaluation and Training** • Evaluator (University or Affiliated) • Vocational Rehabilitation Services
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level Usual Child Welfare/ Substance Abuse Services
Performance Indicators	The program did not include indicator data in the final report.
Sustainability Status	The FACS Child Protection program will continue to receive funding for substance abuse and mental health services through the state's general funds allocated to substance abuse treatment managed by the Division of Behavioral Health (DBH). Currently the DBH provides funds of $750,000 each year for FACS to be able to refer parents involved in the child protection program for a substance abuse assessment and treatment services if needed. This money has historically been spent down at a rate of 100% each year. While this has been sufficient in providing assistance to parents not involved in the Child Protection Drug Court, DBH cannot continue to fund FDC for this population as of July 2013. Fortunately the ISC will be able to continue funding the FDC for this

	population through their allocation of state funds. The ISC is in the preliminary stages of planning for expansion of the Child Protection Drug Courts as well but with initial limited capacity as a pilot in other regions. The following treatment and recovery support services will continue to be funded in the current FDC programs: • Intensive outpatient counseling • Residential treatment • Case management • Transportation • Safe and sober housing • Child care • Drug testing In addition to these services, the FACS substance abuse liaisons will continue to work collaboratively with Child Protection Drug Court coordinators to ensure that appropriate clients continue to be referred to the FDC. FACS and ISC will continue to meet at least quarterly and further improve this partnership. DBH will continue to be a stakeholder and will participate in meetings as needed to facilitate continued cooperation between ISC and FACS.
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Project Evaluator and Contact Information	Debra Aubrey, Evaluator 921 S. 8th Ave. Stop 8174 Pocatello, ID 83209 aubrdebr@isu.edu

Name of Lead Agency	**Children's Research Triangle (CRT)**
Location	**Chicago, IL**
Title of Project	**Family and Child Treatment Services (FACTS)**
Program	RPG 5-Year Grant (2007-2012); $1,000,000 annually

Option	
Geographic Area and Congressional District Served	St. Clair County Congressional District 12
Brief Program Description	The FACTS project was a collaborative effort between the CRT, the Illinois Department of Children and Family Services (DCFS), Southern Illinois Healthcare Foundation and Chestnut Health Systems to promote family safety and permanency for children in the western region of Southern Illinois who were affected by prenatal or environmental substance exposure. Partners implemented an integrated and collaborative system of care to identify and address the developmental, behavioral and mental health needs of the affected child and family. This collaborative system of care included: • prenatal screening for substance use • follow-up screening by the pediatrician • comprehensive medical, neurodevelopmental and psychological assessments • specialized child and family clinical programs (i.e., individual and group therapy, trauma specific services, parenting programs and coordinated care management) • substance abuse treatment for parents and caregivers • extensive community outreach and education regarding the impact of prenatal or environmental substance exposure.
Target Population	FACTS served children from birth to 18 years of age (or 21 if still involved with DCFS or if the caregivers maintained guardianship) living in the western region of Southern Illinois and affected by prenatal or environmental exposure and in one of the following placements • Intact family or out-of-home placement with DCFS including children residing with birth families, in kinship or traditional foster homes, residential and group home placements and independent and transitional living programs • Children in subsidized or legal guardianship placements or adoptive homes • Biological family in which either or both parents are in substance abuse treatment, but with no involvement with DCFS • Biological family in which the pregnant woman had a positive screen for substance use on interview during routine care at Southern Illinois Healthcare Foundation utilizing the 4P's Plus, but no report to DCFS was made

Participants Served	Children: 483 Adults: 550 Families: 461
Major Goals	**Major program goals included:** • Integrating Systems – Public and private agencies delivered collaborative services within an integrated system of care • Outreaching to Families – Families were educated on the effects of prenatal and environmental exposure and how to access services for the family • Providing Professional Training – Increase number of professionals in Southern Illinois who demonstrate knowledge about the impact of prenatal and environmental exposure and provide comprehensive assessment and treatment services to children who have been exposed • Coordinating Referrals – DCFS caseworkers and substance abuse treatment providers referred prenatally or environmentally exposed children for a full assessment of cognitive, behavioral, developmental and mental health functioning and specialized therapeutic services • Assessing Clients – The physical and behavioral health status of prenatally or environmentally exposed children in Southern Illinois improved through the delivery of specialized, comprehensive assessment services • Treating Clients – The physical health and behavioral health status of prenatally and environmentally exposed children and families in Southern Illinois will be improved through the delivery of specialized, comprehensive treatment services • Increasing Permanency and Safety – Permanency, safety and stability for children who have been prenatally or environmentally exposed to methamphetamine or other substances will be increased
Key Major Program Services	**Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program-Nurturing Parenting **Mental Health and Trauma Services for Adults** • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Children's Services** • Developmental Services • Mental Health Services for Children/Youth – Dyadic Developmental Psychotherapy

	• Trauma Services for Children/Youth – Trauma-Focused Cognitive Behavioral Therapy, Structured Psychotherapy for Adolescents Responding to Chronic Stress **Substance Abuse Prevention Services** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Trauma • Specialized Screening and Assessment – Pre-natal exposure/risk, Developmental, Behavioral/Socio-Emotional, Psychosocial **Screening and Assessment – Substance Use and Other Adult Issues** • Specialized Screening and Assessment – Parenting, Mental Health/Co-Occurring Disorders **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing/Motivational Enhancement Therapy • Organizational Outreach – NIATx • Co-location of Staff
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare • Child Welfare Services Provider **Substance Abuse** • State Substance Abuse Agency • Substance Treatment Provider **Courts** • Family Drug Court • Juvenile Justice Agency **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Dependency/Juvenile Courts • Criminal Courts • County Juvenile Justice Agency • Law Enforcement • Office of the Attorney General • Court Appointed Special Advocates **Mental Health** • Mental Health Services Provider

	Health Services • County Public Health/Maternal Child Health • Children's Dental • Adult Health Services Provider – Federally Qualified Health Center (FQHC) • Children's Health Services Provider (FQHC) **Education** • County/Regional School District • Individual School(s) **Other Community and Child and Family Services** • Other Community Stakeholder Group **Other Evaluation and Training** • Consultant/Training
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	**Safety** Children Remain at Home: All 31 children who were identified as at risk of removal from their home were able to remain within the custody of their parent or caregiver throughout their involvement in the program. **Adult and Child Well-Being** Parental Stress: Of the parents who completed both baseline and follow-up Parenting Stress Index (PSI) measures, 42.8 percent demonstrated a change from clinical to non-clinical in their level of parental stress. Developmental Assessments: Of children and youth in the treatment group, 86.9 percent were assessed for developmental needs compared to only 15.5 percent in the comparison group. Mental Health Assessments: With respect to mental health needs, 93.3 percent of the treatment group was assessed for these needs with 65.2 percent of this group accessing services, as compared to 10.3 percent of the comparison group assessed and only 9.9 percent accessing services.
Sustainability Status	**The screening and referral system was fully sustainable for the project. Program components that will continue to be sustained included:** • Prenatal screening and referral • Pediatric developmental screening

	• Therapy for children and families by Southern Illinois Healthcare Foundation and other community providers
Project Director and Contact Information	Dr. Ira Chasnoff, Medical Director Children's Research Triangle 180 N. Michigan Ave., Suite 700 Chicago, IL 60601 (312) 726-4011 ichasnoff@cr-triangle.org
Project Evaluator and Contact Information	Anne Wells, PhD, Director of Research Children's Research Triangle 180 N. Michigan Ave., Suite 700 Chicago, IL 60601 (312) 726-4011 awells@cr-triangle.org

Name of Lead Agency	**One Hope United-Hudelson Region**
Location	**St. Louis, MO**
Title of Project	**One Hope United**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	St. Louis County Congressional District Statewide
Brief Program Description	The Circle of Hope project was designed to increase the well-being and improve the safety and permanency outcomes for children affected by methamphetamine and other drugs in Missouri's Southwestern Region by 1) augmenting the State and Regional interagency service delivery infrastructure, and 2) developing a seamless, integrated, family-centered service delivery system at the local level. The project served families whose children were at-risk of removal as a result of parental drug use, through an Intensive Family Services Team (IFST) model. The program used the guiding principles of the Strengthening Families approach to modify the Homebuilder's Program for the target population. Enhanced

	and expanded collaboration was achieved across partner systems through the development of the Missouri Alliance for Drug Endangered Children (MODEC) at the State level and the Southwestern Alliance for Drug Endangered Children (SADEC) at the Regional level.
Target Population	**The project targeted:** The purpose of the Circle of Hope project was to increase the well-being of and improve the permanency outcomes for children affected by methamphetamine or other substance abuse by: • Augmenting the inter-agency service delivery infrastructure • Developing a seamless, integrated, family centered service delivery system
Participants Served	Children: 208 Adults: 164 Families: 109
Major Goals	**Major program goals included:** • Augment Services Infrastructure by: Providing a framework for an intensive level of support for families involved with methamphetamine and other drugs in Missouri and developing the Missouri Alliance for Drug Endangered Children (MODEC) and the Southwestern Alliance for Drug Endangered Children (SADEC) • Develop Service Delivery Systems by: Providing an enhanced level of support to families that have been involved in the manufacturing, distribution and/or use of methamphetamine and other drugs
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Wraparound/Intensive In-Home Comprehensive Services **Parenting/Family Strengthening** • Manualized Parenting Curriculum or Evidence-Based Parenting - Nurturing Parenting **Family Therapy/Counseling** **Mental Health and Trauma Services for Adults** • Trauma-Informed Services • Trauma-Specific Services – Covington Programs, Beyond Trauma **Substance Abuse Treatment for Adults** • Residential/Inpatient Treatment – Specialized for Parents with Children – Matrix Model

	• Intensive Outpatient – Matrix Model • Non-Intensive Outpatient or Other Step-Down • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing **Family-Centered Substance Abuse Treatment** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Other Specialized Child Screening and Assessment – Developmental, Behavioral/Socio-Emotional, Mental Health/Psychological **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Trauma, Domestic Violence, Family Functioning
Partner Agencies and Organizations	**Child Welfare** • Missouri Department of Social Services, Children's Division, State, Regional and Local **Substance Abuse** • Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, State and Regional **Courts** • 31st Judicial Circuit (Juvenile Court), local **Other Community and Child and Family Services** • One Hope United (lead agency) **Other Evaluation and Training** • Missouri Institute of Mental Health (Local Evaluator)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level The evaluation included both process and outcome questions.
Performance Indicators	Children remain at home: The families enrolled in the Circle of Hope were significantly less likely to have their children removed from the home, than the service-as-usual parents.

	Occurrence of child maltreatment: Children of parents engaged with the Circle of Hope were significantly less likely to have any child maltreatment formally reported to DSS-Children's Division than their service-as-usual peers. Children connected to supportive services: of parents engaged with the Circle of Hope were significantly more likely to have been assessed for any developmental needs compared to their service-as-usual peers. • Children of parents engaged with the Circle of Hope were significantly more likely to have received services for any developmental needs compared to their service-as-usual peers. • Children of parents engaged with the Circle of Hope were significantly more likely to have been assessed for any mental health needs compared to their service-as-usual peers. • Children of parents engaged with the Circle of Hope were significantly more likely to have received services for any mental health needs compared to their service-as-usual peers. • Children of parents engaged with the Circle of Hope were significantly more likely to have been assessed for any educational needs compared to their service-as-usual peers. • Children of parents engaged with the Circle of Hope were significantly more likely to have received services for any educational needs compared to their service-as-usual peers. Improved child well-being: The NCFAS-G Overall Child Well-being subscale refers to the child's physical, mental, and emotional health in respect to his or her behavior; school performance; relationship with parents, siblings, and peers; and cooperation/motivation to maintain or stay with the family. Retention in substance abuse treatment: Parents engaged with the Circle of Hope were significantly more likely to enter substance abuse treatment than their service-as-usual peers. Parents engaged with the Circle of Hope stayed in substance abuse treatment for a significantly longer period of time than their service-as-usual peers (mean numbers days 133 versus 95 days). Substance use: The Drug/Alcohol use section of the ASI is used to gather some basic information about the participant's substance abuse history. It addresses information about current and lifetime substance abuse, consequences of abuse, periods of abstinence, treatment episodes, and financial burden of substance abuse. Parents or caregivers connected to supportive services: The NCFAS-G Overall Social/Community Life subscale refers to the family experience with social relationships, relationships with child care, schools and extracurricular services, connections to neighborhood, and to

	cultural/ethnic community, connection to spiritual and religious community, and caregiver's initiative and acceptance of available help and support. Employment: Baseline data were collected on a total of 177 participants, 93 from the intervention group and 84 from the control group. At 6 months, 59 interviews were completed on the intervention group and 84 from the control group. At six months, 59 interviews were completed on the intervention group and 72 were completed on the control group. At 12 months, 46 interviews were completed on the intervention group and 53 were completed on the control group. Criminal behavior: The legal status section of the ASI is used to gather some basic information about a participant's legal history. It addresses information about probation or parole, charges, convictions, incarcerations, or legal detainments, and illegal activities. Baseline data were collected on a total of 131 participants, 57 from the intervention group and 74 from the control group. At six months, 32 interviews were completed on the intervention group and 54 were completed on the control group. At 12 months, 35 interviews were completed on the intervention group of 40 were completed on the control group. Mental health status: The NCFAS-G, Overall Family Health refers to the family experience with caregiver physical health, disability, mental health, child physical health, child disability, child mental health, and family access to physical and mental health care. Parenting: The NCFAS-G Overall Parental Capabilities subscale refers to family experiences with supervision of children, disciplinary practices, provision of developmental and enrichment opportunities, mental or physical health, use of drugs/alcohol, promotion of children's education, controlling access to media, and parent's literacy. Family relationships and functioning: The NCFAS-G Family Interactions subscale refers to bonding experiences with children, communication with children, expectations of children, mutual support, and the relationship between parents, routines, family recreation and play activity. Difficulties with overall family interaction included weaknesses in areas such as: bonding with children, communicating with children, and demonstrating use of family routines. Risk/protective factors: The NCFAS-G Overall Environment subscale refers to family experience with housing stability, safety in the community, environmental risks, habitability of housing, personal hygiene and the learning environment. Coordinated case management: All families enrolled in the Circle of Hope intervention group received joint case management services between One Hope United, the child welfare provider, and the substance abuse treatment provider.

	Family involvement in the case planning process was achieved through the use of a family treatment plan based on the NCFAS-G. The family care plan included strengths and challenges for each family member, the two NCFAS-G domains identified by the family as focus areas during the first phase of services (generally three months), and goals associated with the domains that were accompanied by measurable objectives. This approach to developing a treatment plan allowed each member of the family to see their role in the work ahead and gave family members an active voice in setting the goals and objectives for improving domains of family functioning. Client satisfaction with this process and all services was measured on an annual basis through the consumer surveys administered by One Hope United. The consumer surveys are discussed in more detail in the Process Evaluation section of this report. Collaborative capacity: Collaborative capacity was, in part, increased in Greene County through the joint training and work groups to address barriers identified during the course of service. This increased understanding across the agencies was demonstrated in the changes measured in the Collaborative Values Inventory. Capacity to serve families: The number of treatment programs, families served, and treatment slots in the region did change over the course of the Circle of Hope project but these changes were the result of outside factors and the efforts of partner agencies. Some of these changes were the result of partner agencies receiving federal funding for new treatment approaches (the Pregnant & Post-partum Women program at AO Treatment Services). As with the Circle of Hope funding, federal does not easily translate to state or local funding so while capacity increased for the short-term, it does not necessarily result in long-term changes. The number of substance abuse treatment slots did increase by the end of the grant but these changes were the result of a new state-wide focus on community-based rather than residential treatment services. At the beginning of the Circle of Hope project, a woman and her children admitted to residential treatment could expect to stay between 21 and 30 days. By the end of the Circle of Hope project, the typical length of stay at the in-patient residential facility was seven days. By reducing the amount of time a woman and children stayed in residential services, there were more slots available to serve families each year.
Sustainability Status	The Missouri Alliance for Drug Endangered Children (MODEC) the state-level collaboration component of this project continues to operate at the State and Regional levels. The Circle of Hope project was not sustained after funding ended. Two of the RPG partners, Alternative Opportunities, Inc. and the local Children's Services Division partnered to successfully apply for a RPG II grant.
Project	Patricia Griffith, Executive Director

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Name of Lead Agency	**Multnomah County**
Location	**Portland, OR**
Title of Project	**Multnomah County, Department of County Human Services, Mental Health and Addiction Services/ Family Involvement Team (FIT)**
Program Option	RPG 5-Year Grant; $1,000,000 annually
Geographic Area and Congressional District Served	Multnomah County Congressional District 1 and 3
Brief Program Description	This program is a collaboration with Multnomah County Department of County Human Services, Mental Health and Addiction Services Division (grantee) partnering with local drug and alcohol and treatment providers, Volunteers of America, Family Drug Court, and the State Department of Human Services. Through RPG funding the grantee and partners sought to expand and enhance the family drug court, known as the Family Involvement Team (FIT), with the goal of connecting parents with appropriate alcohol and drug treatment as expeditiously as possible and supporting them with appropriate services and caring staff so families could stay together or be reunited sooner. The cornerstone of FIT for Recovery was the addition of client case managers at each of the alcohol

	and drug treatment providers. Attainment of project goals was reliant on the addition of a mix of services identified by the project partners. The project partners had a history of working collaboratively for approximately five years prior to the grant application, offering a fixed array of resources to clients. The RPG provided the grantee an opportunity to address gaps in services for mothers and their children and to add services for dads of color. Services for men, especially minority specific services for male parents whose partners are involved with Child Welfare, were woefully lacking in Multnomah County. The grantee worked on infrastructure development through a Family Involvement Team Operations Committee and an Executive Board that has a history of consensus based systems development.
Target Population	**The project targeted:** The target population of FIT for Recovery prior to the grant was limited to Multnomah County parents with an allegation of child abuse or neglect with alcohol or drugs involved. With the expansion of services through this grant, Child Welfare workers were able to refer any client thought to have involvement with drugs and/or alcohol for a screening / assessment at any point in their child welfare case. This much more inclusive treatment model will continue as standard practice.
Participants Served	Children: 3,292 Adults: 2,380 Families: 1,886
Major Goals	**Major program goals included:** To reduce foster care placements and foster care costs by providing immediate access to intensive services, thus taking advantage of parent's motivation at this crisis point in their lives and reducing the time to reunification. • Increase the proportion of Department of Human Services (DHS) involved parents (primarily women) with allegations of child abuse and/or neglect where alcohol and/or drugs are involved who are able to access Family Involvement Team services • Expand the array of services available above the current mix of available services • Increase the engagement, retention, and completion rates in substance abuse treatment of the parents in the FIT project above current documented rates • Expand the service array to address gaps in both services and populations served

	• Improve the current service delivery system through enhanced collaborations to address recent breakdowns in systems that are in need of revitalization.
Key Major Program Services	**Case Management and In-Home Services** • Intensive Case Management **Mental Health and Trauma** • Trauma Informed Services **Substance Abuse Treatment for Adults** • Non-Intensive Outpatient or Other Step-Down • Intensive Outpatient-Matrix Model **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies- Motivational Interviewing • Peer/parent Mentor • Recovery Coach Specialist **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Screening and Assessment for Trauma • Other Specialized Child Screening and Assessment – Developmental, Mental Health/Psychological, Educational **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Psychosocial **Cross-Systems Collaboration** • Clinical and Program Training • Cross-systems policies/ procedures • Regular Joint Case Staffing Meetings • Co-location of Staff
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/County Child Welfare Agency **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Provider

	Courts • Family Treatment Drug Court (FTDC) **Mental Health** • Health Services **Other Community and Child and Family Services** • Peer/Parent/Mentor Group or Network **Other Evaluation and Training** • Evaluator (University or Affiliated) • Consultant/Training
Evaluation Design and Comparison Group Type	Quasi-Experimental Matched Case-level Usual Child Welfare services The project employed a three-part evaluation approach to capture child welfare and treatment related process and outcomes information. Data sources include the following: • Administrative data including SACWIS (child welfare), CPMS (substance abuse treatment) and the FIT database, for both process and outcome information. • Client and stakeholder voice gathered from interviews and focus groups with FIT-served families, FIT staff, and community partners for both process and outcome data. The research design included a "child welfare business as usual" comparison group matched with FIT families using demographic and case characteristics. Due to changes in the State's SACWIS data base the grantee and evaluator were unable to access AFCARS data between June 2011 and January 2013. In addition, they could not use 2012 NCANDS data for any analysis. This created significant delays and challenges for the evaluation.
Performance Indicators	The program did not include performance indicators in the final report.
Sustainability Status	The structure of FIT for Recovery predated the beginning of the Children's Bureau grant in 2007. With the Children's Bureau grant FIT for Recovery expanded: • The number of case managers • The number of parent mentors • Number of clients enrolled annually

	Additionally, FIT expanded services through the addition of a drop-in center for current and former clients and a new parenting education service with staff at each of the residential services providers. The overall program model as it was at the end of the Children's Bureau grant will remain with one exception; the drop in center, Family Recovery Support, is continuing with year to year funding as an ongoing source of funds has not been secured. A mix of local and State Block Grant funds as well as dedicated Child Welfare staff have provided the basic funding and staff support for FIT for Recovery. The cornerstone of FIT for Recovery has been the client case managers at each of the alcohol and drug treatment providers. These case managers plus State funded outreach workers and certified alcohol and drug specialists at each child welfare branch office are the core of FIT for Recovery. Continued full funding of the seven FIT case managers is supported by the results from a combination of client interviews, focus groups with clients, and surveys with key informants. Focus groups of current and former clients and a web survey of Child Welfare case workers consistently ranked outreach and case management at each treatment agency as the most important FIT services and supports. The FIT Executive Committee supported these findings by approving continued funding for case managers as their highest priority.
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Name of Lead Agency	**State of Nevada**
Location	**Carson City, NV**

Title of Project	Dependency Mothers Drug Court (DMDC)
Program Option	RPG 5-Year Grant; $5,000,000 annually
Geographic Area and Congressional District Served	Clark County Congressional District 1 and 3
Brief Program Description	Coordinate and expand service capacity in Clark County to increase timely access to appropriate substance abuse treatment, integrate child welfare and substance abuse and ultimately improve the safety, permanency and well-being of children and families affected by methamphetamine abuse and child maltreatment.
Target Population	**The project targeted:** • Women and children in Clark County who are involved in the welfare system and are meth abusers
Participants Served	Children: 135 Adults: 67 Families: 74
Major Goal	**Major program goal:** • Promote reduction in the number of out-of-home placements for children, or the number of children who are at risk of being placed in an out-of-home placement in Clark County through the development of strengthened system of care for methamphetamine-affected families in child welfare.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Comprehensive Services **Parenting/Family Strengthening** • Enhanced Parenting Services • Evidence-Based Parenting or Family Strengthening Program – Nurturing Families **Visitation Services** • Supportive Supervised Visitation

Family Therapy/Counseling

Engagement/Involvement of Fathers

- Targeted Outreach

Mental Health and Trauma Services for Adults

- Mental Health and Psychiatric Care Including Medication Management
- Trauma-Informed Services
- Trauma-Specific Services – Covington Programs

Substance Abuse Treatment for Adults

- Long-Term Residential/Inpatient (more than 30 days)
- Residential/Inpatient Treatment – Specialized for Parents with Children
- Aftercare/Continuing Care/Recovery Community Support Services

Specialized Outreach, Engagement and Retention

- Cognitive Behavioral Strategies – Motivational Interviewing
- Co-location of Staff
- Peer/Parent Mentor

Family-Centered Substance Abuse Treatment

Substance Abuse Prevention Services

- Prevention Education

Screening and Assessment – Child Welfare and Other Children's Issues

- Screening and Assessment for Child Welfare Issues
- Other Specialized Child Screening and Assessment – Developmental, Psycho-Social

Screening and Assessment – Substance Use and Other Adult Issues

- Screening and Assessment for Substance Use Disorders
- Other Specialized Adult Screening and Assessment – Mental health/Co-Occurring Disorders, Parenting

Children's Services

- Early Intervention and Developmental Services
- Trauma Services for Children/Youth – Trauma-Focused Cognitive/Behavioral Therapy (TF-CBT)

Cross-Systems/Interagency Collaboration

- Clinical and Program Training
- Cross-systems Policies and Procedures

	• Regular Joint Case Staffing Meetings • Co-location of Staff • Cross-systems Information Sharing and Data Analysis • Partner Meetings **Other** • Employment/Job Readiness **Housing Services** • Housing Support and Assistance Services **Family Treatment Drug Court**
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare • Regional/County Child Welfare **Substance Abuse** • State Substance Abuse Agency • Substance Abuse Treatment Agency **Courts** • Family Treatment Drug Court (FTDC) • Other Dependency Court • State Court **Criminal Justice/Law Enforcement/Legal/Related Organization** • Attorney **Mental Health Services** • State Mental Health • Mental Health Service Provider **Evaluator** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Pre-experimental No group
Performance Indicators	Upon completion of treatment, 100% of women were employed and lived in transitional housing.

	• At the conclusion of treatment, all women maintained custody of children born while in treatment. • All children that were part of an open case at the start of treatment were reunified with their mother, and remained in mother's custody at successful treatment completion. This represents a 100% reunification rate for women who complete treatment. • Mothers completing treatment leave with significantly lower parental stress when compared to mothers at intake, post-reunification (if applicable), and post-birth (if applicable). Mothers showed significant increases in parental stress after reunification or birth of a newborn, but generally reported less stress at the next admission of the PSI, demonstrating the effectiveness of the RPG in promoting healthy parent/child attachment and interaction.
Sustainability Status	Based on the Nevada award under RPG2, the Dependency Mothers Drug Court (DMDC), which was formed as part of the original RPG program, will continue to operate within the Clark County Family Court System. Most existing program components will remain stable, and a variety of refinements and enhancements will be made to various program components to create a better comparison group design and adhere to the existing and proposed EBPs. The group of RPG stakeholders will be narrowed and no longer include the Court Improvement Project (CIP) or the Attorney General (AG)'s Office. The DMDC has ongoing access to training and CIP resources because the Clark County Family Court is part of Nevada's Eighth Judicial District. All judicial districts in the state currently work with the CIP as part of its statewide training and improvement activities.
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Project Evaluator and Contact Information	Sean Westwood Odes, Inc. 1171 Amarillo Ave Apt 2 Palo Alto, CA 94303 800-297-4173 sean@odesinc.org

Name of Lead	**Child and Family Tennessee**

Agency	
Location	**Knoxville, TN**
Title of Project	**New Beginnings for Women and Children**
Program Option	RPG 5-Year Grant (2007-2012); $1,000,000 annually
Geographic Area and Congressional District Served	Knox County and East Tennessee Congressional District 2
Brief Program Description	New Beginnings for Women and Children, also referred to as New Beginnings, began as a partnership between Child and Family Tennessee, a nonprofit agency, and the Knox County and East Tennessee Regions of Tennessee's Department of Children's Services (DCS) in 16 East Tennessee counties. The program impacts the lives of pregnant women and mothers of small children who abuse substances, helping them to access and receive gender-specific model treatment services that contribute to their success as mothers and success in life. The program provides comprehensive treatment services to mothers affected by substance use, particularly methamphetamine, and their children. New Beginnings emphasizes a family-centered approach and thus, children are permitted to stay with their mothers on the residential treatment campus until the mother completes her treatment. Objectives included: • Providing evidenced-based substance abuse treatment for addicted mothers • Providing family-centered services including wraparound and development services for children • Building regional capacity through our East Tennessee Regional Partnership • Conducting a rigorous match comparison evaluation study
Target Population	**New Beginnings targeted:** Mothers (pregnant or parenting a child age 0-3) who abused methamphetamine or other substances and who may be dually diagnosed with a mental health disorder
Participants Served	Children: 398 Adults: 250 Families: 250

Major Goals	**Major program goals included:** • Protecting children from harm or neglect • Improving coordination and integration of knowledge on children affected by methamphetamine or other substances
Key Major Program Services	**Case Management** • Intensive Case Management **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Nurturing Parenting **Mental Health and Trauma Services for Adults** • Mental Health Services and Psychiatric Care • Trauma-Informed Services • Trauma-Specific Services – Healing the Trauma of Abuse, Beyond Trauma **Substance Abuse Treatment for Adults** • Residential/Inpatient – Specialized for Parents with Children • Intensive Outpatient – Matrix Model **Family-Centered Substance Abuse Treatment Services** **Children's Services** • Developmental Services • Trauma Services for Children and Youth **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Therapy Strategies – Motivational Interviewing/Motivational Enhancement Therapy • Co-location of Staff
Partner Agencies and Organizations	**Child Welfare** • Department of Children's Services – Knox and East Tennessee Regions University of Tennessee Medical Center, Prenatal Services • Fort Sanders Regional Medical Center, Prenatal Services • East Tennessee Children's Hospital **Substance Abuse/Mental Health** • Child and Family Tennessee – Lead Agency • Courts • Anderson County Juvenile Court • Knox County Drug Court

	• Knox County Juvenile Court • Monroe County Sessions Court • Scott County Drug Court **Health Services** • Knox County Health Department **Housing** • Knox County Community Action Committee • Knox Community Development Corporation **Employment** • Heart of Knoxville Career Center • Other Community and Child and Family Services • Compassion Coalition • TennCorp Community Services, Inc. **Other** • Metro Drug Commission • Blount County Sheriff's Department
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	**Safety** <u>Reunification:</u> Upon entering New Beginnings, 59 mothers (27.0 percent) reported that their children currently live with them. Upon discharge from the program, 8 mothers (4.0 percent) reported regaining physical custody of their children while involved with the program and 3 (1.0 percent) regained legal custody. <u>Substance Exposed Newborns:</u> Twenty-seven mothers (12.0 percent) were pregnant at the time of intake to New Beginnings and 3 (1.0 percent) had given birth in the month prior to intake. After intake, 13 women (6.0 percent) gave birth while enrolled at New Beginnings and 11 (5.0 percent) were pregnant at the time of discharge from the program. Among those children born after program intake, none were reported to have been born with substance exposure due to maternal substance use prior to program intake. **Adult Well-Being** <u>Mental Health Status:</u> The provision of mental health care and prevention services was a critical part of the New Beginnings program. At

	termination, 118 mothers (54.0 percent) had received mental health counseling and 36 (17.0 percent) had received services to help manage their psychotropic medication. Parental Stress: Scores on the Parenting Stress Inventory (PSI) indicate a general decrease in parenting stress in the six months following the baseline interview. This is especially evident for the total scale score and, to a lesser extent, the parent distress subscale. Depression: Mothers involved with New Beginnings experienced a significant decline in depression as measured by the Center for Epidemiological Studies-Depression (CES-D) scale. Scores declined from above 25 at baseline to 10-12 at the time of the 6-month follow-up assessment.
Sustainability Status	• New Beginnings was sustained in its entirety. The continuing components include the East Tennessee Regional Partnership group along with treatment in a supportive living environment in Knox County, TN, and intensive outpatient (IOP) treatment in Blount and Campbell counties. In addition to sustaining the existing components, Child and Family Tennessee added intensive outpatient treatment in Knox County, as well as in-home services in the three DCS regions in East Tennessee to the New Beginnings umbrella of services. • Sustainability for these program components was achieved through a mixture of funding including the Regional Partnership Grant for 2012-2017, continued local and State funding and increased insurance billing.
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Project Evaluator and Contact Information	Laura Denton, PhD 901 East Summit Hill Dr. Knoxville, TN 37915 laura.Denton@child-family.org

Name of Lead Agency	**State of Arizona**
Location	**Phoenix, AZ**

Title of Project	**The Arizona Families F.I.R.S.T. (AFF) Parent to Parent (P2P) Recovery Program**
Program Option	RPG 3-Year Grant (2008-2011); $500,000 annually
Geographic Area and Congressional District Served	Maricopa County Congressional District 4
Brief Program Description	The Arizona Department of Economic Security, Division of Children, Youth and Families, in partnership with TERROS, Inc., Arizona State University's Center for Applied Behavioral Health Policy and other stakeholders came together to expand and strengthen an existing system of care. This Regional Partnership targeted Maricopa County families who were impacted by methamphetamine abuse. The project built on the strengths and capacities of existing service providers to better enhance their collaborative efforts in providing substance abuse and child welfare interventions. The use of Peer Recovery Coaches improved engagement and retention in treatment interventions. This enhanced intervention services were provided to the families by well trained and culturally competent staff to increase engagement in appropriate treatment interventions, reduce substance use and maintain family stability to allow children to remain in their home, while improving family functioning and the safety and well-being of children.
Target Population	**The project targeted:** • Individuals enrolled in the AFF program who resided in Maricopa County • Individuals who received in-home intervention services • Children who were at risk of being removed from home due to parental methamphetamine and other substance abuse
Participants Served	Children: 549 Adults: 673 Families: 673
Major Goals	**Major program goals included:** • Providing comprehensive family-centered services that recognize individual needs and build on family strengths and protective factors to achieve safety, permanency and well-being for children who are at risk of or in out-of-home placement as a result of substance abuse, with a special focus on methamphetamine

	• Integrating the child welfare, substance abuse treatment and court systems into a cohesive infrastructure to strengthen and coordinate family-centered services for families in which children are at risk of or in out-of-home placement as a result of substance abuse
Key Major Program Services	**Case Management and In-Home Services** • Family Group Decision Making/Family Case Conferencing **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment – Substance Use Disorders **Substance Abuse Treatment for Adults** • Residential (Short-Term & Specialized) • Intensive Outpatient • Non-intensive Outpatient • Aftercare/Continuing Care **Specialized Outreach, Engagement and Retention** • Recovery Coach/Specialist **Housing Services** • Housing Supportive Services
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Substance Abuse Treatment Provider **Other Community and Child and Family Services** • Other Child/Family Services Provider **Other Evaluation and Training** • Evaluator (University-Affiliated or other)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level
Performance Indicators	**Recovery** Outreach: Individuals referred to the P2P program received outreach services

	more rapidly (M = 1.69 days following referral) than their counterparts referred to the AFF program (M = 4.86 days following referral). This was found to be statistically significant. Length of Time in Treatment: Among those clients recorded as having completed their treatment program, the average length of treatment among P2P clients was 183 days, in contrast to 141 days among AFF clients. **Permanency** Reunification: Index children in the P2P group were reunified with a parent or caregiver at a significantly higher rate than those children in the matched comparison AFF group. Reunification occurred, on average, a little over a month quicker for index children in the matched comparison AFF group (Mdn = 85 days) than for those in the P2P group (Mdn = 118.5 days). Although the rates of achieving permanency were not different between the P2P and matched comparison AFF groups, there was a significantly higher rate of reunification observed for P2P index children. **Well-Being** Supportive Services: Individuals referred to the P2P program engaged in an assessment approximately four days faster than their AFF program referral counterparts. Nearly all individuals (96.9 percent) referred to the P2P program engaged in some form of service, eclipsing the rate of service engagement observed among the AFF program referrals (89.9 percent). While the rates of counseling service engagement were comparable across samples, those individuals served in the P2P program initiated these counseling services more rapidly (M = 24.91 days) than individuals served in the AFF program (M = 27.76 days).
Sustainability Status	The AFF Parent to Parent Recovery Program model is being incorporated into the statewide substance abuse program scope of work. Several program components were sustained at the completion of the project. For example, TERROS, Inc. was able to integrate the cost of the Peer Recovery Coaches into their AFF budget upon completion of the project. TERROS is a community-based behavioral health organization dedicated to helping people recover from substance abuse, mental illness and other behavioral health problems. Additionally, Northern Arizona has adopted the AFF Parent to Parent Recovery Program model into their service integration. This provider utilizes a Peer Recovery Coach during the outreach and engagement process and when they are providing ongoing supportive services to clients. Funding is through the AFF budget as part of supportive service dollars.
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Name of Lead Agency	**Butte County Department of Employment and Social Services**
Location	**Oroville, CA**
Title of Project	**The Northern California Regional Partnership for Safe and Stable Families (also known as the Butte County RPG)**
Program Option	RPG 3-Year Grant (2008-2011); $500,000 annually
Geographic Area and Congressional District Served	Counties of Butte, Lake, Tehama and Trinity Congressional District 1 & 2
Brief Program Description	The Northern California Regional Partnership for Safe and Stable Families is comprised of four Northern California counties (Butte, Lake, Tehama and Trinity) with support and leadership from University of California at Davis Extension and IDEA Consulting for evaluation activities. The mission of the Butte County RPG was to improve the permanency outcomes for children affected by methamphetamine and/or other substances by providing timely services, engaging families and collaborating and coordinating with their partners. Through enhanced cross-system partnerships, early assessment, diagnosis and treatment, the partnership was able to improve outcomes for families participating in their program.
Target Population	**Butte County RPG served:** All child welfare-involved families affected by substance abuse disorders, including those families where children are at risk of out-of-home placement as a result of methamphetamine and/or other substance abuse

	Women with young children (a priority target population)
Participants Served	Children: 1061 Adults: 801 Families: 581
Major Goals	**Major program goals included:** • Developing shared policies and procedures for sharing information across agencies and counties to enhance communication and planning activities among agencies • Providing cross-agency training within and across counties on collaboration, screening and assessment tools, evidence-based and best practice service models and strategies for implementing information sharing, outcomes and evaluation techniques • Developing screening instruments for use by Child Welfare Services (CWS) to identify substance use in families and protocols for immediate referral to Alcohol and Other Drug (AOD) services • Developing screening instruments for use by AOD services to identify indicators of suspected child abuse and neglect and protocols for immediate referral to CWS • Identifying and developing evidence-based best practices, culturally relevant treatment models for AOD programs designed for parents involved with Child Welfare Services (especially for women with young children), specific programs for treating methamphetamine addiction and techniques for utilizing Dependency Drug Courts in the treatment process
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing **Mental Health and Trauma** • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment – Child Welfare Issues • Specialized Child Screening and Assessment – Developmental **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Nurturing Parenting **Engagement and Involvement of Fathers**

	• Targeted Outreach to Fathers • Specialized Program or Services for Fathers **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Therapy Strategies – Motivational Interviewing/Motivational Enhancement Therapy • Co-located Staff
Partner Agencies and Organizations	**Substance Abuse** • Regional/County Substance Abuse Treatment Agency **Courts** • Family Drug Court **Mental Health** • County Public Health **Education** • College or University (non-evaluator role) • Individual School(s) • Early Childhood Services/Education Provider • Parenting Education/Services Provider **Other Evaluation and Training** • Evaluator (University-Affiliated or Other) • Consultant/Training
Evaluation Design and Comparison Group Type	Pre-experimental
Performance Indicators	**Family Functioning or Child Well-Being** Family Relationships and Functioning: Across the four counties, 462 of the 801 parents or caregivers (57.7 percent) had a child remain in the home or were reunified with a child. These parents showed improved parent-child interactions by being reunified with one or more children and/or maintaining their child at home. **Recovery** Timely Access to Treatment: There were 801 parents enrolled in substance use treatment in the Butte County RPG project. For these 801 parents, the average number of days between program entry and treatment entry in the four-county cohort was three days.

	Treatment Retention: Of the 801 adults enrolled in substance use treatment, 506 clients were discharged. Of the 506 parents who were discharged, 151 clients (29.8 percent) successfully completed substance use treatment.
Sustainability Status	Three of the four counties have been able to creatively sustain the positions which were developed as a result of this grant funding. In addition, the values and treatment models have become standard practice for all four counties, with families being active leaders in their treatment. The multi-agency collaboration and shared treatment planning activities will continue in all four counties.
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Project Evaluator and Contact Information	Nancy M. Callahan, President IDEA Consulting 2108 Alameda Ave. Davis, CA 95616 (530) 758-7655 nancycal@dcn.davis.ca.us

Name of Lead Agency	**Supreme Court of Georgia**
Location	**Atlanta, GA**
Title of Project	**Family Treatment Systems Collaborative; Appalachian and Douglas Family Dependency Treatment Courts (FDTCs)**
Program Option	RPG 3-Year Grant (2008-2011); $500,000 annually
Geographic Area and Congressional District Served	Douglas, Appalachian Circuit (Fannin, Gilmer and Pickens Counties) Congressional Districts 3, 9 & 13
Brief Program	The Appalachian and Douglas Family Dependency Treatment Courts

Description	(FDTCs) applied the Family Drug Court model to serve families over a four-year period. The intervention consisted of participation in intensive substance abuse treatment, consistent judicial oversight, frequent and random drug screening and a variety of ancillary services all provided within the oversight by a judge-led, interdisciplinary collaborative team. Key agencies represented on the team included the juvenile court, the Department of Children and Families Services (DFCS), Court Appointed Special Advocates (CASAs), treatment providers and attorneys representing both children and parents.
Target Population	**The project served families with:** • Parental substance abuse that has deleteriously impacted the children • Children under the age of four • Referral from the local Department of Family and Children's Services (DFCS), Georgia's Child Protective Services agency
Participants Served	Children: 157 Adults: 105 Families: 90
Major Goals	**Major program goals included:** • Improving caregiver outcomes by helping parents to maintain sobriety, decreasing family stress, improving parent-child interactions and decreasing child abuse and neglect • Improving child outcomes by promoting child safety • Having the courts improve the content and delivery of supportive services for mental and physical child development • Decreasing involvement in the Child Welfare System by reducing out-of-home placements • Reuniting children with their parents after out-of-home placements • Promoting safe, healthy home environments with functional caregivers for all children in the system
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Services **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Nurturing Parenting, Celebrating Families! **Mental Health and Trauma**

	• Mental Health Services & Psychiatric Care • Trauma-Informed Services **Substance Abuse Treatment for Adults** **Engagement/Involvement of Fathers** • Targeted Outreach to Fathers **Screening and Assessment – Child Welfare and Other Children's Issues** • Specialized Child Screening and Assessment – Developmental, Mental Health, Trauma, Behavioral, Socio-Emotional **Children's Services** • Early Intervention Services • Developmental Services • Therapeutic Services • Trauma Services **Housing Services** • Housing Supportive Services • Housing Assistance • Transitional/Short-Term Housing
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Substance Abuse Treatment Provider **Other Community and Child and Family Services** • Other Child/Family Services Provider **Other Evaluation and Training** • Evaluator (University-affiliated or other)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level
Performance Indicators	**Family Well-Being** Qualitative Data: Findings from the focus groups indicated that participating in the FDTC has increased sobriety, social and relational support, community connectedness, parenting skills and new ways of

	thinking. An increase in the participants' confidence has allowed them to be much better parents than they had been prior to their participation. **Recovery** Continued Sobriety: Participants in Appalachian Circuit had a significantly lower rate of positive drug screens than their counterparts in the Douglas FDTC. The average percent of screens positive in the Appalachian Circuit was 1.0 percent, whereas in the Douglas FDTC it was 10.0 percent. **Permanency** Reunification: Of 67 participants who had at least 1 child removed (and for whom reunification status was known), 26 (38.0 percent) had their children returned to them by the end of the study period. Fifteen participants who had not regained custody (48.0 percent of those not regaining custody) remained active participants in the program and are working towards achieving custody. Together, these figures suggest that the FDTCs are providing parents with the opportunity to regain custody of their children, should they participate meaningfully in the program.
Sustainability Status	The Appalachian FDTC was expanded during the final year of the grant and the number of participants enrolled across the two courts during year four exceeded the number enrolled in any of the previous three funded years. Towards the end of the grant period, Governor Nathan Deal of Georgia asked that 10 million dollars be allocated statewide to expand accountability courts, which included the family drug courts (i.e., the programs will be sustained in full). Furthermore, a case manager position was secured through county funding.
Project Director and Contact Information	Jenny McDade Douglas Family Dependency Treatment Court 8700 Hospital Dr., 3rd Floor Douglasville, GA 30134 (770) 920-7121 jmcdade@co.douglas.ga.us
Project Evaluator and Contact Information	Kevin Baldwin Applied Research Services, Inc. 663 Ethel St. NW Atlanta, GA 30318 (404) 881-1120, Ext. 104 kbaldwin@ars-corp.com

Name of Lead Agency	**Omaha Nation Community Response Team (ONCRT)**
Location	**Walthill, NE**
Title of Project	**Omaha Nation Community Response Team (ONCRT) "Sacred Child" Program (SCP)**
Program Option	RPG 3-Year Grant; $ 500,000 annually
Geographic Area and Congressional District Served	Omaha Reservation Congressional District 1
Brief Program Description	The ONCRT assisted American Indian families involved with substance abuse through the SCP. The SCP utilized "Walking in Beauty on the Red Road" (WBRR), an evidence-based approach to providing intensive adolescent outpatient treatment, community outreach and recovery support services. SCP activities also assisted the community in developing a recovery support infrastructure on the Omaha Reservation, which encompasses all of Thurston County and portions of Burt and Cuming Counties in Northeastern Nebraska and Monona County in Iowa.
Target Population	**The project targeted:** • Families involved in substance abuse • Adolescents (children under the age of 18) involved in the child welfare and juvenile justice systems
Participants Served	Children: 62 Adults: 61 Families: 62
Major Goals	**Major program goals included:** • Providing an effective and comprehensive recovery support infrastructure on the Omaha Reservation in Northeast Nebraska • Undertaking WBRR, a culturally relevant, evidence-based substance abuse program, for youth involved with the child welfare and juvenile justice systems on the Omaha reservation • Integrating WBRR into both new and existing family outreach programs to provide a comprehensive approach to building youth awareness, recruitment and referral into the program

	• Establishing the Sacred Child Center, coordinating the WBRR program and facilitating family involvement, mentoring and recovery support services
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Wraparound/Intensive In-Home Support Services **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Positive Indian Parenting **Screening and Assessment – Child Welfare and Other Children's Issues** • Youth Substance Abuse Screening and Assessment • Specialized Child Screening and Assessment – Mental Health, Suicidal Ideation, Trauma, Education **Children's Services** • Adolescent Outpatient Alcohol and Other Drug Services • Therapeutic Services • Trauma Services • Remedial/Academic Supports **Specialized Outreach/Engagement** • Cultural Knowledge and Identity Development **Mental Health and Trauma** • Trauma-Specific Services-Walking in Beauty on the Red Road **Substance Abuse Treatment for Adults** • Family Centered Treatment
Partner Agencies and Organizations	**Child Welfare** • Child Welfare Services Provider **Substance Abuse** • State Substance Abuse Agency • Regional/County Substance Abuse AgencyTribal Substance Abuse Treatment Provider **Courts** • Tribal Juvenile Court • Tribal Juvenile Probation

	Criminal Justice, Law Enforcement, Legal and Related Organizations • Tribal Law Enforcement • Tribal Prosecutor • Legal Services/Client Advocacy **Mental Health and Health Services** • Tribal Mental Health Services Provider • Indian Health Services • Tribal Health Services Provider/Clinic **Education** • Local School District • Individual School • Early Childhood Services • Education Provider • Parenting Education/Services Provider **Employment** • Tribal Social Services • State Temporary Assistance for Needy Families or Welfare Office **Other Community and Child and Family Services** • Home Visiting Program or Services Provider • Church or Faith-based Organization • Domestic Violence Services Provider/Agency • Peer/Parent Mentor Group or Network **Other Evaluation and Training** • Evaluator (University-Affiliated or Other) • Consultant/Training
Evaluation Design and Comparison Group Type	Pre-experimental
Performance Indicators	**Child Well-Being** Children Supportive Services: The percentage of children/youth assessed with serious depression decreased from 85.0 percent to 60.0 percent from program intake to completion. Family Relationships and Functioning: School attendance increased from

	75.0 percent to 90.0 percent for children/youth. Child Well-being: The reported use of alcohol or drugs went from 100.0 percent to 25.0 percent and arrests went from 60.0 percent to 30.0 percent between intake and aftercare for the participating children and youth in SCP. **Recovery** Adult Support Services: It was estimated that 75.0 percent of the adults later participated in supportive services about which they heard in an earlier meeting.
Sustainability Status	The Omaha Tribe is considering re-implementing the SCP utilizing Tribal resources.
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Project Evaluator and Contact Information	Neal Grandgenett, PhD University of Nebraska at Omaha 107 Kayser Hall Omaha, NE 68182 (402) 554-2690 ngrandgenett@mail.unomaha.edu

Name of Lead Agency	**University of Rochester**
Location	**Rochester, NY**
Title of Project	**Fostering Recovery: Supporting Young Children Exposed to Substance Abuse and Their Families**
Program Option	RPG 3-Year Grant; $ 500,000 annually
Geographic Area and Congressional	Monroe County Congressional District 28

District Served	
Brief Program Description	Fostering Recovery was a product of the regional partnership between the University of Rochester's Mt. Hope Family Center, the Monroe County Department of Human Services and the New York State Monroe County Family Court. The purpose of the program was to address the complex relational needs of families in Monroe County who were dealing with chemical dependency, especially those who have infants and toddlers (birth to three years old). Fostering Recovery employed multiple evidenced-based, relational interventions (i.e., Child Parent-Psychotherapy, Attachment and Bio-Behavioral Catch-Up and Relational Recovery Group), as well as a Rapid Referral Program for substance abuse treatment and mechanisms to enhance early intervention utilization designed to enhance children's well-being. The projected supported parental recovery in four ways, which included: 1) providing rapid referrals to treatment providers; 2) allowing individuals to see themselves as healthy parents for their children; 3) linking success in recovery to children's positive outcomes; and, 4) improving the parent-child attachment relationship, which reinforces parental responsibility and sobriety.
Target Population	**The project targeted:** • Families dealing with chemical dependency, especially those with infants and toddlers
Participants Served	Children: 66 Adults: 67 Families: 66
Major Goals	**Major program goals included:** • Enhancing the parent-child relationship • Supporting emotional security in young children living at home or in foster care • Increasing the social, emotional and cognitive development of young children living at home or in foster care • Reducing out-of-home placements for children who remain at home • Decreasing the time until children in foster care are permanently placed • Enhancing parental participation and success in conventional chemical dependency treatment
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management **Housing Services**

	• Housing Supportive Services • Housing Assistance **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing/Motivational Enhancement Therapy, Moral Reconation Therapy • Recovery Coach • Co-located Staff **Children's Services** • Developmental Services • Therapeutic Services • Trauma Services - Child Parent Psychotherapy (CPP) **Mental Health and Trauma** • Mental Health Services • Trauma-Informed Services • Trauma-Specific Services **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Nurturing Parenting Program
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Substance Abuse Treatment Provider(s) **Courts** • Family Drug Court **Health Services** • Children's Health Services Provider/Hospital **Education** • College or University (non-evaluator role)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level

Performance Indicators	**Safety** Children Remain at Home: Ninety-six percent of RPG children remained at home in the custody of their parent or caregiver through RPG program case closure. Maltreatment: After entering the RPG program, 93.9 percent of the children did not experience any maltreatment, compared to 79.4 percent of comparison group children. **Recovery** Treatment Retention: Among those discharged from substance abuse treatment, 40.0 percent of RPG adults completed treatment, compared to 33.3 percent of comparison adults. **Adult Well-Being** Mental Health: The number of participants with mild to moderately elevated depressive symptoms improved from baseline to discharge.
Sustainability Status	Rochester was able to sustain Child Parent Psychotherapy (CPP) and the evaluation of all services provided. CPP, which is included in SAMHSA's National Registry of Evidence-Based Programs and Practices, was sustained through various efforts by: • Integrating the CPP into a SAMHSA-funded National Child Traumatic Stress Network grant that focuses on promoting resilience and providing treatment for children who have experienced trauma • Partnering with Starlight Pediatrics, a specialized pediatric clinic for children in foster care, to provide CPP and other trauma treatment at a new Visitation Center in Monroe County, and as part of a CDC grant • Partnering with the Department of Human Services Preventive Unit to provide CPP as a contracted service • Securing local, State and Federal funding to support an evidence-based home visitation program, of which CPP is component, for mothers who gave birth before the age of 21 • Securing local funding to provide CPP to traumatized families whose children are in urban child care centers
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Project	Sheree Toth, PhD

Evaluator and Contact Information	Mt. Hope Family Center 187 Edinburgh St. Rochester, NY 14608 (585) 275-2991, Ext. 248 s.toth@worldnet.att.net

Name of Lead Agency	**County of Lucas**
Location	**Toledo, OH**
Title of Project	**Pre-Removal Family Drug Court Program**
Program Option	RPG 3-Year Grant (2008-2011); $500,000 annually
Geographic Area and Congressional District Served	Lucas County Congressional District 9
Brief Program Description	The purpose of the Pre-Removal Family Drug Court Program was to expand and improve the continuum of services provided by the Lucas County Family Drug Court. **The program's objectives included:** • Engaging substance abusing participants in treatment at the earliest point of their contact with child protection services • Facilitating earlier and safer reunification, especially for young children • Addressing a fuller spectrum of family problems which contribute to child maltreatment **The project's approach included:** • Providing drug court services to "pre-removal" child protection cases either by contract, prior to filing in court or upon filing, with a request for Lucas County Children Services' (LCCS) protective supervision • Providing supportive housing for pre- and post-removal drug court participants, in which reunification could occur and new sobriety and parenting skills could be practiced under supervision
Target Population	**Lucas County Juvenile Court served:**

	• Substance abusing parents whose children have been removed due to maltreatment • Families who have an open child protection case predicated on substance abuse and whose children remain at home
Participants Served	Children: 266 Adults: 164 Families: 142
Major Goals	**Major program goals included:** • Continuing to establish collaboration among the agencies involved in the development and implementation of the Pre-Removal Family Drug Court Program • Establishing and finalizing the program structure for the Pre-Removal Family Drug Court Program • Developing a plan for sustainability of the Post-Removal Family Drug Court Program
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Celebrating Families! **Mental Health and Trauma** • Psychiatric Care • Trauma-Specific Services **Substance Abuse Treatment for Adults** • Aftercare/Continuing Care • Family-Centered Treatment • Expanded and enhanced Family Dependency Treatment Court **Specialized Outreach Children's Services** • Early Intervention Services • Developmental Services • Trauma Services • Substance Abuse Treatment for Children/Youth **Housing Services** • Housing Support Services and Assistance • Emergency Housing

	• Transitional/Short-Term housing • Permanent Supportive housing • Permanent Housing **Engagement/Involvement of Fathers** • Targeted Outreach to Fathers h, Engagement and Retention • Cognitive Behavior Therapy Strategies – Contingency Management • Co-located Staff
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Provider(s) **Courts** • Family Treatment Drug Court • Juvenile Justice Agency • Court Appointed Special Advocates **Criminal Justice, Law Enforcement, Legal and Related Organizations** • State Department of Corrections (including State probation and prisons) • County Corrections (including county/local probation and jails) • Local Law Enforcement • Attorney(s) General • Legal Services/Client Advocacy **Mental Health and Health Services** • Regional/County Mental Health Agency • Mental Health Services Providers • Adult Health Services Provider/Hospital • Children's Health Services Provider/Hospital **Housing** • Housing/Homeless Services Provider **Employment** • Employment Services Provider **Other Community and Child and Family Services** • Home Visiting Agency or Services Provider

	• Church or Faith-based Organization • Domestic Violence Services Provider/Agency **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	**Safety** Average Length of Stay in Foster Care: Lucas County Family Drug Court (LCFDC) had 54 FDC children and 20 comparison children discharged from foster care. All 54 FDC children and 20 comparison children were discharged to reunification. The mean length of stay in foster care was 87 days for the FDC children and 219.9 days for the comparison children. Timeliness of Reunification: Of the 54 children in LCFDC, 52 children (96.3 percent) were reunified in less than 12 months. It should also be noted that 38 children (73.0 percent) in the LCFDC program were reunified in less than 3 months. **Recovery** Access Timely and Appropriate Substance Abuse Treatment: In the LCFDC program, 148 adults were admitted to substance abuse treatment. For the LCFDC program the average number of days to treatment entry from RPG entry was listed as 50 days. Reduction of Use: In 100.0 percent of the cases in LCFDC, there was a reduction in substance use from treatment intake to discharge.
Sustainability Status	With the assistance of the Ohio Department of Alcohol and Drug Addiction Services grant, the court continued to contract with Lucas County Treatment Accountability for Safer Communities for two case manager positions. The maximum capacity of the program decreased to 40 clients versus 60 clients without the additional case manager that was funded by the RPG grant. The LCCS and the Mental Health and Recovery Services Board reported continuing funding for fiscal year 2011-2012 in the amount of $450,000 for treatment services for all LCCS clients, which include LCFDC clients.
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Name of Lead Agency	**Cook Inlet Council, Inc.**
Location	**Anchorage, AK**
Title of Project	**Alaska Native Family Preservation (ANFP) Program**
Program Option	RPG 5-Year Grant (2007-2012); $500,000 annually
Geographic Area and Congressional District Served	Cook Inlet Congressional District 1
Brief Program Description	Cook Inlet Tribal Council (CITC) implemented a Regional Partnership Grant project that integrated State and Tribal partners to provide child welfare/protection and substance abuse treatment services in Anchorage, AK. CITC leveraged and expanded child welfare services in its existing Child & Family Services and Recovery Services departments through its partnership with the State of Alaska Office of Children's Services (OCS) and the Native Village of Eklutna (NVE), a local Tribe in the Cook Inlet region.
Target Population	**ANFP served:** • Alaska Native/American Indian (AN/AI) families in Anchorage who have substantiated reports of child abuse or neglect and are at risk of further involvement with the child protection system
Participants Served	Children: 524 Adults: 435 Families: 192

Major Goals	**Major program goals included:** • Increasing the well-being of, improving the permanency outcomes for and enhancing the safety of AN/AI children who were at risk of out-of-home placement as a result of a parent's or caretaker's substance abuse • Decreasing the number of out-of-home placements for children, or the number of children who are at risk of out-of-home placement • Increasing the ability of the Anchorage community to address parental/caretaker substance abuse and its effect on AN/AI children
Key Major Program Services	**Case Management and In-Home Services** • Wraparound/Intensive In-Home Comprehensive Services **Family Therapy/Counseling** **Engagement/Involvement of Fathers** • 24/7 Dad AM/PM **Mental Health and Trauma Services for Adults** • Trauma-Informed Services • Trauma-Specific Services **Substance Abuse Prevention Services** • Housing Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing/Motivational Enhancement Therapy • Co-location of Staff • Screening, Brief Intervention and Referral to Treatment (SBIRT) **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Trauma • Specialized Screening and Assessment – Developmental, Behavioral/Socio-Emotional
Partner Agencies and Organizations	**Child Welfare** • State of Alaska Children's Services • CITC Family Services **Substance Abuse** • CITC Recovery Services, Southcentral Foundation, Salvation Army, Akeela

	Tribal • Native Village of Eklutna (other Tribes via Indian Child Welfare Act workers) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Alaska Native Justice Center **Other Evaluation and Training** • UAA Child Welfare Academy **Mental Health and Health Services** • Southcentral Foundation, Anchorage, Community Mental Health Services, North Star Hospital • Southcentral Foundation • Alaska Native Medical Center **Education** • Nine Star **Employment** • CITC's Tribal Temporary Assistance for Needy Families • Alaska's People **Other Community and Child and Family Services** • Disability Services – ARC of Anchorage, Hope Cottages, Infant Learning Program • Domestic Violence – Abused Women's Aid in Crisis, Southcentral Foundation Willa's Way
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level The evaluation plan also used qualitative data to describe and measure performance indicators, with special attention to implementation processes.
Performance Indicators	**Family and Child Well-Being** <u>North Carolina Family Assessment Scale (NCFAS) Well-Being Measures:</u> Participants of the ANFP treatment group demonstrated increases in all five areas measures by the NCFAS with the greatest increase being seen in Safety. <u>Qualitative Data:</u> In focus groups completed with program participants, clients expressed the need for even greater emphasis on planning for graduation from the program and desired greater opportunities for aftercare and recovery supports.

Sustainability Status	**CITC was able to sustain several component of the RPG program:** • Intensive In-home Services: Intensive home-based services continued for the target population within CITC's Child & Family Services department through an OCS grant-funded program referred to as the Intensive Family Preservation Program. • Comprehensive Assessment and Service Planning: Program strategies have been institutionalized both in CITC's continuum of services and in OCS's Practice Model. • Culturally Resonant Services/Enhanced Parenting Services: CITC and NVE maintained a collaborative relationship in the implementation of the Tribal IV-B programs to promote culturally resonant strategies. In the Cook Inlet Region, CITC and NVE are implementing Positive Indian Parenting and family strengthening activities for Tribal members. • SBIRT: CITC maintained SBIRT in the Child & Family/Recovery Services programs. CITC is developing a general screening process for all participants of services across the agency to include SBIRT and wellness indicators. This process was initiated using iPad technology. These strategies are sustained internally through Indian Health Service funding implemented by CITC.
Project Director and Contact Information	Deborah Northburg 3600 San Jeronimo Dr., Ste. 138 Anchorage, AK 99508 (907) 793-3134 dnorthburg@citci.com
Project Evaluator and Contact Information	Spero M. Manson, PhD, Professor and Department Head American Indian and Alaska Native Programs School of Medicine, University of Colorado Denver Mail Box F800, P.O. Box 6508 Aurora, CO 80045 (303) 724-1444 spero.manson@ucdenver.edu

Name of Lead Agency	**CenterPoint, Inc**
Location	**San Rafael, CA**

Title of Project	Family Link
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Marin County Congressional District 6
Brief Program Description	The focus of the project was to strengthen and enhance the existing FamilyLink program, an integrated service model serving women, dependent children, and their families within the Center Point residential facility in San Rafael, CA. Center Point, in partnership with the Marin County Child Welfare System (CWS), sought to reduce the effects of methamphetamine and other substance use on the children and their families involved with the CWS. FamilyLink offered an array of on-site rehabilitation services including healthy birth outcomes for pregnant women. Adult participants received culturally appropriate, trauma-informed ongoing care to address substance use, mental health disorders, parenting training, vocational services, independent living skills and other needs in order to promote long-term sobriety and family reunification. FamilyLink also provided a safe, structured, educational, and stable environment for children to reside in while their mothers sought treatment for their own substance use and mental health disorders. All children were enrolled in quality educational services through Head Start.
Target Population	**The project targeted:** Families that met the following criteria: • Women from Marin County, California in need of substance use and mental health disorder treatment • Involved in the child welfare system (CWS) and who were either at risk of losing their children or had temporarily lost custody of their children (i.e., those not meeting the goals of their reunification plans) • Had dependent children who were not necessarily involved in the CWS, but were at a heightened risk for losing custody of their children due to their substance use • Dependent children who were involved in both the dependency and justice systems.
Participants Served	Children: 152 Adults: 147

	Families: 147
Major Goals	**Major program goals included:** • Inform the CWS' understanding of the links between substance use and child abuse and neglect through joint case management by Center Point staff and child welfare personnel. • Increase the number of parents entering substance abuse treatment services by 25% as measured by child welfare and Center Point case records. • FamilyLink will enhance the successful completion rate by reducing the percentage of clients who drop out or are involuntarily discharged from the program as measured by discharge status. • FamilyLink will provide opportunities designed to increase the parental capacity of participants to provide for their children's needs • Reduce parent-child separation of children of mothers with substance abuse problems
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing **Parenting/Family Strengthening** • Manualized Parenting Curriculum or Evidence-Based Parenting – Celebrating Families, Parenting Now **Family Therapy/Counseling** **Engagement/Involvement of Fathers** • Targeted Outreach **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma Informed Services • Trauma Specific Services – Seeking Safety, Covington Programs, Helping Women Recover, Beyond Trauma, Healing Journey for Women **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies - Motivational Interviewing, Motivational Enhancement Therapy, Contingency Management **Children's Services** • Early Intervention and Developmental Services • Mental Health Counseling

	• Trauma Services for Children/Youth – Parent Child Interaction Therapy **Other Strategies** • Co-Located Head Start Therapeutic Day Care • Dedicated Off-Site Head Start Classroom • Recovery Coach/Specialist • Peer/Parent Mentor • Transportation
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency • Child Welfare Services Provider **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Provider **Courts** • Family Treatment Drug Court (FTDC) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • County Corrections **Health Services** • County Public Health **Housing** • Housing/Homeless Services Provider **Education** • Early Childhood Services/Education Provider • Parenting Education/Services Provider **Employment** • Employment Services Provider
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance	**Safety**

Indicators	Recurrence of Maltreatment: None of the children in FamilyLink experienced an initial occurrence and/or recurrence of child maltreatment between RPG entry and discharge. **Permanency** Children Remain At Home: None of the children residing in treatment with their mothers at Center Point were removed from their mothers' care prior to their mothers' discharge from the program. Reunification: The rate of family reunification was high; of the 64 mothers who did not have custody of their child when they began FamilyLink, 55 (85.9%) were reunited during program participation. **Well-Being** Substance Exposed Newborns: Seven children were born while their mothers resided in treatment; none of them were substance exposed at birth. **Recovery** Treatment Completion: At the end of the FamilyLink project, the overall treatment completion rate was 59.7%. Prior to this project, the treatment completion rate at Center Point's residential program for women was 53.3%. A majority (63.7%) of the 149 women discharged from FamilyLink were successfully discharged, including 59.7% who completed treatment and 4.0% who transferred to another treatment program. Employment: Only 5.8% of clients were employed prior to enrolling in the program. Among the 149 clients discharged from the program, 47.0% were employed full or part time at discharge.
Sustainability Status	In 2012 Center Point, Inc. responded to the Request for Proposals for Round Two of the Regional Partnership Grants and was a recipient of a new five year grant to continue the FamilyLink program and services through 2017. In addition, Center Point applied for and was awarded a four year grant to provide comprehensive support services for families affected by substance abuse and/or HIV/AIDS. FamilyLink Plus, the new program, offers an opportunity to expand and enhance services offered to women with dependent children and will include family visits, parenting education, and fatherhood services through 2016.
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Project Evaluator and Contact Information	Meg Knight Pima Prevention Partnership 2525 E. Broadway, Suite 100 Tucson, AZ 85716 (520) 624-5800 x 1403 (520) 624-5811 (fax) mknight@thepartnership.us

Name of Lead Agency	**County of San Diego, Health and Human Services Agency Child Welfare Services**
Location	**San Diego, CA**
Title of Project	**County of San Diego, Child Welfare Services**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	San Diego County Congressional District 50-52
Brief Program Description	The Family Integrated Treatment (FIT) Program, an initiative of the County of San Diego's Health and Human Services Agency's Divisions of Child Welfare Services and Alcohol and Drug Services, in partnership with Rady Children's Hospital - San Diego, McAlister Institute, Vista Hill Foundation and Mental Health Systems Inc., provided enhanced services for mothers struggling with methamphetamine and other drug addiction. The program provided: • Evidence-based parenting development for mothers • Structured evidenced informed developmental and trauma assessments • Evidence based trauma treatment for children • Enhanced visitation for families with children in out-of-home placements
Target Population	**The project targeted:** San Diego County - East, South and North Coastal Regions Active or referred families with children aged 0-8 who are at risk of out of home placement due to mother's methamphetamine or other substance Abuse whose mothers are receiving outpatient recovery services.

Participants Served	Children: 597 Adults: 400 Families: 400
Major Goals	**Major program goals included:** • To provide comprehensive assessment and trauma treatment services for children of mothers in outpatient drug treatment programs. • To enhance parent development services for mothers in outpatient drug treatment programs. • To provide enhanced visitation and therapy for families with mothers in outpatient drug treatment programs. • To increase system capacity and collaboration.
Key Major Program Services	**Case Management and In-Home Services** • "Traditional" Case Management • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing **Parenting/Family Strengthening** • Standard Parenting Skills Training • Enhanced Parenting Services • Evidence-Based Parenting or Family Strengthening Program – Incredible Years **Visitation Services** • Supervised Visitation • Supportive Supervised Visitation **Family Therapy/Counseling** **Mental Health and Trauma Services for Adults** • Mental Health Services and Psychiatric Care • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Substance Abuse Treatment for Adults** • Long-Term Residential/Inpatient (more than 30days) • Residential/Inpatient Treatment – Specialized for Parents with Children • Partial Hospitalization • Intensive Outpatient – Matrix Model • Non-Intensive Outpatient or Other Step-Down

	• Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing • Peer/Parent Mentor • Co-location of Staff **Family-Centered Substance Abuse Treatment** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Screening and Assessment for Trauma • Other Specialized Child Screening and Assessment – Developmental, Behavioral/Socio-Emotional **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Parenting, Psychosocial, Mental Health/Co-Occurring Disorders, Trauma/Domestic Violence **Children's Services** • Early Intervention and Developmental Services • Remedial/Academic Supports • Mental Health Counseling • Trauma Services for Children/Youth – Parent Child Interaction Therapy (PCIT), Parent Child Attunement Therapy, (PCAT), Child Parent Psychotherapy (CPP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) **Cross-Systems/Interagency Collaboration** • Clinical and Program Training • Cross-systems Policies and Procedures • Regular Joint Case Staffing Meetings • Co-location of Staff • Cross-systems Information Sharing and Data Analysis • Partner Meetings **Housing Services** • Housing Assistance
Partner Agencies and	**Child Welfare**

Organizations	• Regional/ County Child Welfare Agency **Substance Abuse** • Substance Abuse Treatment Agency/ Provider(s) **Courts** • Other Dependency Courts **Mental Health and Health Services** • Mental Health Services Provider(s) • Children's Health Provider/Hospital **Other Community and Child and Family Services** • Other Child/Family Services Provider **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-time, Matched Population-Level
Performance Indicators	**Safety** Recurrence of maltreatment: The percentage of children in the treatment group that experienced an occurrence and/or recurrence of maltreatment within 6 months was 4.5% while it was 5.8% for the comparison group. Likewise, at 12 months, the percentage of children that experienced an occurrence/and/or recurrence of maltreatment was lower for the treatment group (2.9%) than for the comparison group (7.0%). **Permanency** Length of Stay in Foster Care: Children in the treatment group had a lower median number of days in foster care (median 371 days) than the comparison group (median = 552.5).
Sustainability Status	Able to sustain specific components/scaled down version of program model
Project Director and Contact Information	Moses Savar, CWS Policy Analyst 8965 Balboa Ave, 2nd Floors San Diego, CA 92123 (858) 616-5940 Moses.savar@sdcounty.ca.gov

Project Evaluator and Contact Information	Harder and Company Community Research 3965 5th Avenue, Suite 420 San Diego, CA 92103 (619) 398-1980

Name of Lead Agency	**County of Santa Cruz, Health Services Agency, Alcohol and Drug Program**
Location	**Santa Cruz, CA**
Title of Project	**Treatment Alliance for Safe Children**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Central Coast of Santa Cruz Congressional District 17
Brief Program Description	The Treatment Alliance for Safe Children (TASC) project was a collaboration between Santa Cruz County Health Services Agency's Alcohol and Drug Program, Human Services Department's Family & Children's Services (Child Welfare Services), the Superior Court, and a network of community based service providers. TASC served families who resided in all regions of Santa Cruz County; and served an average of 81 adult clients, 112 children and 71 families a year. The Family Preservation Court (FPC), the central program in the TASC project, was a highly successful voluntary treatment court dedicated to assisting parents in addressing their substance abuse issues to increase the likelihood of either reunification with their children or to prevent removal of their children due to abuse and neglect. The Regional Partnership Grant (RPG) enabled the County to enhance and expand this original "Dependency Drug Court" to provide a continuum of intensive case management and individually tailored, culturally competent treatment and ancillary services.
Target Population	**The project targeted:** Families that met the following criteria: • Families residing in Santa Cruz County, California with methamphetamine or other drug abuse issues • Families who volunteer to participate in the Family Preservation Court program

	• Families with a child in out-of-home placement (Family Reunification) or families with court-ordered in-home placement (Family Maintenance) • Families that have a child age 12 or under • Parent needs a placement of Level II.1 (Intensive Outpatient Treatment) or higher, based on a comprehensive substance use assessment and application of American Society of Addiction Medicine patient placement criteria
Participants Served	Children: 293 Adults: 219 Families: 189
Major Goals	**Major program goals included:** • Implement Expanded and Enhanced Dependency Drug Court • Improve Child Outcomes • Improve Adult and Family/Relationship Outcomes • Improve Regional Partnerships and Service Capacity
Key Major Program Services	**Case Management and In-Home Services** • Intensive Case Management • Family Group Decision Making/Family Case Conferencing • Home Visits **Family Therapy/Counseling** **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma-Informed Services **Substance Abuse Treatment for Adults** • Intensive Outpatient – Matrix Model • Non-Intensive Outpatient or Other Step-Down • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies - Motivational interviewing • Co-location of Staff • Peer/Parent Mentor **Children's Services** • Early Intervention and Developmental Services

	• Mental Health Counseling – Parent Child Interaction Therapy, Trauma Focused Cognitive Behavioral Therapy **Family Treatment Drug Court/Dependency Drug Court**
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency **Courts** • Family Treatment Drug Court (FTDC) **Mental Health Services** • Regional/County Mental Health Agency • Mental Health Service Provider **Education** • Parenting Education/Services Provider **Employment** • State/County Temporary Assistance for Needy Families (TANF) or Welfare Office **Other Community and Child and Family Services** • Domestic Violence Services **Other Evaluation and Training** • Evaluation (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Historical, Matched Population-Level
Performance Indicators	**Safety** The majority of children (84.5%) did not experience an occurrence of child maltreatment after enrollment in program services. **Permanency** Approximately three-quarters of the children in the home at time of enrollment remained in the home at case closure. The median length of stay in foster care for those reunified was significantly

	shorter for TASC (10.8 months) than comparison children (14.3 months). **Recovery** A total of 232 TASC (97.9%) and 23 comparison (95.8%) adults were admitted to substance abuse treatment. The median[13] length of stay in treatment for those that completed treatment was significantly longer for TASC (364.0 median days or 12.0 months) than comparison adults (124.0 median days or 4.1 months). **Well-Being** Six children were born to TASC mothers while they were enrolled in the program and for all of the children no substances were detected at birth. Nearly all of the adults who needed received continuing care services (96.4%), parenting services (94.9%), dental services (87.6%), domestic violence services (87.3%), employment services (83.0%) and child care services (80.0%). Approximately three-quarters of the adults who needed received primary medical care (76.4%), transportation services (76.1%) and mental health services (71.8%).
Sustainability Status	The grantee reports serving fewer participants post-grant funding and a portion of the funding Child Welfare allocated for treatment of non-FPC clients is currently being used to help support the program. CalWORKs funding and California realignment funds that were allocated for the original dependency drug court are also being used.
Project Director and Contact Information	Lynn Harrison, Project Director 1400 Emeline Ave Santa Cruz, CA 95060 (831) 454-5499
Project Evaluator and Contact Information	Colleen Killian Children and Family Futures, Inc. Research and Evaluation Division 23571 Commercentre Suite 140 Lake Forest CA 92630 (714) 505-3525 CKillian@cffutures.org

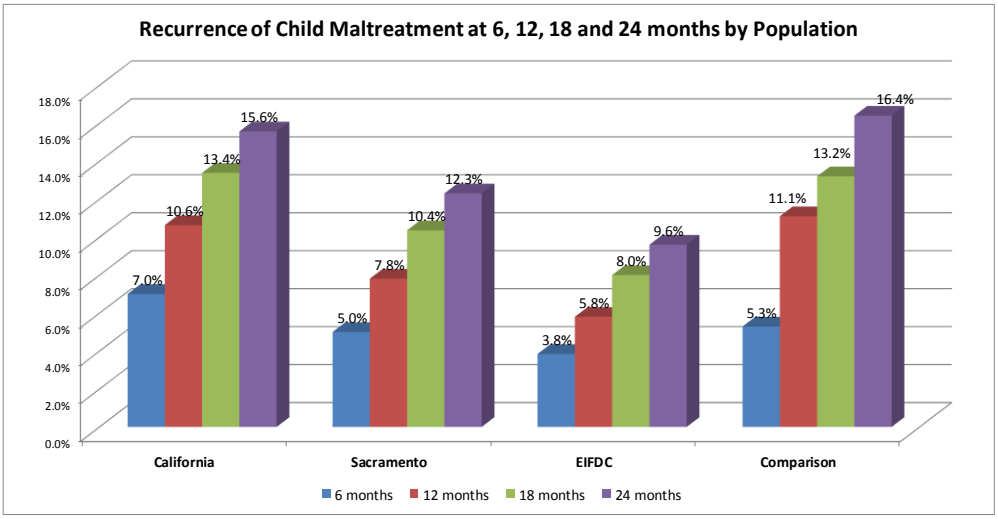
[13] The *median* number of days is reported here, in contrast to the *mean*, as the median is considered a better measure of the typical length of stay for adults in the treatment sample, especially since the sample size for treatment discharges is small. Because the *mean* is the arithmetic average of the entire range of possible values, it tends to be more sensitive to and affected by outliers, particularly very high values.

Name of Lead Agency	**Sacramento Department of Health and Human Services**
Location	**Sacramento, CA**
Title of Project	**Early Intervention Family Drug Court (EIFDC)**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Sacramento County Congressional District 3 and 5
Brief Program Description	The Early Intervention Family Drug Court (EIFDC) was developed as a collaborative project by Sacramento County's Department of Health and Human Services (DHHS) divisions of Child Protective Services and Behavioral Health Services. Although EIFDC began in association with the Superior Court (Juvenile Dependency Division), because of funding constraints in November 2010 the project lost access to courtrooms and judicial oversight. Due to the strength of the collaboration, EIFDC was able to continue and on January 5, 2011 an inaugural EIFDC proceeding was conducted by a hearing officer in a conference room in a county building. The EIFDC program continues to function as a pre-plea or administrative court rather than a formal court calendar or docket leading to a new model of family court programming. Like all Family Drug Courts, the purpose of EIFDC is to protect the safety and welfare of children while providing the resources parents need to become sober, responsible caregivers. EIFDC program components include intensive case management, supervision by a hearing officer, random drug testing and substance use treatment. Results from the program evaluation unequivocally demonstrates the program's success leading to decrease in trauma for children, an increase in cost savings, and a decrease in case load
Target Population	**The project targeted:** The initial EIFDC target population consisted of families in which the mother had been screened for substance use during pregnancy and/or the newborn baby tested positive for substances at the time of delivery. The EIFDC included fathers of substance-exposed infants as part of its target population. In late 2009, the target population was expanded to include children aged 0-5 with prenatal or postnatal substance exposure and their siblings.

Participants Served	Children: 1,274 Adults: 892 Families: 729
Major Goals	**Major program goals included:** • Establishing an Early Intervention Family Drug Court where hearings provide the additional structure and accountability for parents while they are provided with case management services and participate in treatment services. • Establish linkages for families to individualized parent/child resiliency program and community-based support services such as *Celebrating Families!* parenting program and Birth and Beyond Family Resource Centers for education and ongoing supportive services. • Develop and train staff and partners on project policies and procedures related to the identification, referral and engagement of parents in resiliency, supportive and recovery services. • Use multiple venues of internal and external reporting sources (local newspapers, internal newsletters and presentations) to dissemination of up to date information on positive outcomes and testimonies of personal successes. • Monitor results of inter-agency collaboration through regular meetings of committees to discuss program operations /effectiveness, evaluation reports and identify areas needing improvement. • Evaluation data and findings are shared regularly to identify areas needing improvements and accomplishments.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • "Regular" or "Traditional" In-Home Services **Parenting/Family Strengthening** • Standard and Enhanced Parenting Skills Training • Evidence-Based Parenting or Family Strengthening Program – Celebrating Families **Family Therapy/Counseling** **Engagement/Involvement of Fathers** • Targeted Outreach **Substance Abuse Treatment for Adults** • Intensive Outpatient – Matrix Model • Non-Intensive Outpatient or Other Step-Down

	• Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing • Recovery Coach/Specialist • Peer/Parent Mentor **Family-Centered Substance Abuse Treatment** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Other Specialized Child Screening and Assessment – Developmental **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Psycho-Social **Children's Services** • Developmental Services • Mental Health Counseling **Cross-Systems/Interagency Collaboration** • Clinical and Program Training • Cross-systems Policies and Procedures • Regular Joint Case Staffing Meetings • Cross-systems Information Sharing and Data Analysis • Partner Meetings **Family Treatment Drug Court**
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Provider **Courts** • Family Treatment Drug Court (FTDC) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Attorneys **Mental Health and Health Services**

	• Mental Health Services Providers • County Public Health **Education** • Early Childhood Council/Coalition **Other Community and Child and Family Services** • Home Visiting Agency/Services Provider **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Historical, Matched Population-Level Some specialized non-RPG services
Performance Indicators	**Children Remain at Home** EIFDC children (92.1%) were significantly more likely to remain in-home through case closure than comparison children (69.5%). Put another way, just 7.9% of EIFDC children were removed from their homes prior to case closure, compared to 30.5% of similar children who did not participate in EIFDC. This finding is fundamental to one of the main goals of EIFDC, that is, participation in the program will reduce the rate of removal, allowing children to remain at home. **Occurrence/Recurrence of Maltreatment** Recurrence of maltreatment is defined as the percentage of children who had an initial occurrence and/or recurrence of substantiated child maltreatment after enrolling in the RPG program at intervals ranging from six to 24 months after RPG entry.



Access to Treatment

Of the 775 EIFDC parents who entered substance abuse treatment, 9.5% did so prior to entry into the EIFDC program, 2.1% began treatment the day they started EIFDC, and 86.8% entered treatment following enrollment in the EIFDC program. The entry date for twelve participants (1.5%) was unknown. In contrast, 90(98.9%) comparison adults began substance abuse treatment following the date of selection into the comparison condition and one (1.1%) did so before this point. EIFDC adults (M= 38.1 days) experienced significantly shorter waits to enter substance abuse treatment following their project start date than comparison adults (M= 58.1 days); F (1, 761) = 8.778, p= .003.

Retention in Treatment

Participants who completed treatment or who left before treatment completion with satisfactory progress (whether or not they were referred or transferred) are considered to have completed treatment. Those who left before treatment completion and had unsatisfactory progress were coded as unsuccessful or non-completers. Although, EIFDC (68.0%) participants were no more likely to complete treatment than comparison (69.0%) participants. EIFDC parents stayed in treatment significantly longer (*M*= 131.6 days), however, than parents in the historical comparison condition (*M*= 102.7 days); *F* (1, 463) = 9.422, *p*= .002.

Sustainability Status

The Sacramento EIFDC collaborative team was able to sustain all collaborative practices and services to families. Child Welfare has continued funding four Recovery Specialist positions, has provided the space for weekly administrative hearings, has funded a half time Senior Office Assistance to help with data entry, and other duties in the weekly assembly of the administrative court. In referencing the ability to sustain practices and services, this should be stated as the court existed at the conclusion of the grant funded portion. Due to significant county funding cuts, the program

	was unable to dedicate Public Health Nurses to administer developmental assessments on every child; however, this does not mean children in the target population do not receive such assessments when referred by the social worker. Resources to sustain EIFDC are not only financial. The depth of commitment exhibited by administrators over the past seventeen years to implement significant policy and practice reforms is an intangible but powerful input. This commitment has ensured that the County has one of the best cross-trained professional staffs in the nation. Since 1995, all workers have been required to participate in joint training on substance abuse, child welfare and the courts. Another support for sustainability is represented by the system reforms instituted to support practice change at the front line. Sacramento County's investment over the past eleven years to improve its information systems to efficiently monitor parents and children has contributed to the infrastructure supporting its FTDCs. An additional resource is the County's experience with leveraging non-Federal funds for this population. State General Fund allocations include, Perinatal, the Supportive and Therapeutic Options Program (STOP) and Drug Court Realignment. These funds have been used successfully to provide recovery support to CPS families. In the collaborative effort to sustain the current EIFDC, a percentage of AOD treatment funds for which a child welfare parent would be eligible have been specifically identified in AOD treatment provider contracts for EIFDC parents. These and other resources will continue to be explored by the workgroup to ensure long-term viability and sustainability of the EIFDC.
Project Director and Contact Information	Marian Kubiak, Program Manager 6045 Watt Ave North Highlands, CA 95660 kubiamb@saccounty.net
Project Evaluator and Contact Information	Holly Child 25371 Commercentre Drive Suite 140 Lake Forest, CA 92630 (714) 505-3525 hchild@cffutures.org

Name of Lead Agency	**WestCare California, Inc.**
Location	**Fresno, CA**

Title of Project	Screening, Making Decisions, Assessments, Referrals, Treatment (SMART-2)
Program Option	RPG 5-Year Grant; $ 500,000 annually
Geographic Area and Congressional District Served	Fresno County Congressional District 9
Brief Program Description	The SMART-2 Model of Care Partnership was created by WestCare California, Inc. and its community partners in Fresno County, CA, as an extension of SMART which was implemented in 2004. The approach was designed to build on an existing interagency collaboration of children's services, focusing on an often un-served or underserved population of children of substance abusing parents, with the overall goal of improving the safety, permanency and well-being of the children and their families affected by methamphetamine and other substance abuse. The SMART-2 services targeted parents, and their children (birth to 12 years old), who were enrolled in WestCare's residential and outpatient substance abuse treatment programs. An array of research-based interventions was provided onsite through the Children's Centers to the parents and their children. In addition, parents also received linkage services.
Target Population	**The project targeted:** • Un-served and underserved children birth to 12 years of age who were at risk for medical, mental health, emotional, developmental and learning problems as a result of parental substance use • Parents and family members of the un-served and underserved children aforementioned
Participants Served	Children: 841 Adults: 470 Families: 470
Major Goals	**Major program goals included:** • Improving the coordination of services • Increasing therapeutic services to children of substance abusing parents • Improving the mental health, functioning, parenting skills and home environment of substance abusing parents

	• Increasing the knowledge and skills of field professionals in child welfare, practitioners and provider agency staff on issues affecting children of substance abusing parents and their families
Key Major Program Services	**Case Management** • Family Group Decision Making/Family Case Conferencing **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Nurturing Parenting, Positive Parenting, Incredible Years **Engagement/Involvement of Fathers** **Mental Health and Trauma Services for Adults** • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety, Beyond Trauma **Substance Abuse Treatment for Adults** • Long-Term Residential/Inpatient – Matrix Model • Residential/Inpatient – Specialized for Parents with Children **Children's Services** • Early Intervention and Developmental Services **Housing Services** **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing/Motivation Enhancement Therapy, Moral Reconation Therapy, Contingency Management **Substance Abuse Prevention Services** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Trauma • Specialized Screening and Assessment – Developmental, Behavioral/Socio-Emotional, Speech/Language
Partner Agencies and Organizations	**Child Welfare** • County Child Welfare • Child Welfare Service Provider **Courts** • Dependency Court **Education** • Early Childhood Education

	• County School District • College/University • Early Childhood Education Services Provider • Early Childhood Council • Parent Education Service Provider **Health Services** • County Public Health/ Maternal Child Health • County Public Health/ Other • Children's Health Services Provider **Mental Health** • Mental Health Services Provider **Employment** • State/County Temporary Assistance for Needy Families **Other Community and Child and Family Services** • Child and Family Services Provider • Domestic Violence Services Provider
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level
Performance Indicators	**Recovery** Substance Use: The percentage of women reporting alcohol and drug use within 30 days decreased from 71.9 percent to 18.9 percent from program admission to the six-month follow-up. **Child Well-Being** Child Well-Being: Children enrolled in the SMART-2 Program maintained or increased their developmental state on all measures with the exception of gross motor while their parents were enrolled in treatment. **Adult Well-Being** Mental Health Status: Parents had less depressive symptoms after treatment than upon entering treatment as measured by the Beck Depression Inventory-II (BDI-II).
Sustainability Status	WestCare was able to sustain the following components of the RPG program:

	• Children of parents enrolled in WestCare's residential program will continue to receive developmental and trauma screenings • Children will continue to be referred to Exceptional Parents for follow-up assessments and linked to community services when warranted • Parenting programs will continue to be provided to parents enrolled in WestCare's residential treatment program
Project Director and Contact Information	Lynn Pimentel WestCare CA, Inc. SMART-2 P.O. Box 12107, Fresno, CA 93776 (559) 498-3987 lynn.pimentel@westcare.com
Project Evaluator and Contact Information	Melissa Rhea Western/Pacific Island Regions WestCare Foundation P.O. Box 12107, Fresno, CA 93776 (559) 265-4800, Ext. 20159 melissa.rhea@westcare.com

Name of Lead Agency	**AspenPointe Health Network**
Location	**Colorado Springs, CO**
Title of Project	**Project Aware**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	El Paseo County Congressional District 5
Brief Program Description	The purpose of the Fourth Judicial District Family Reunification Grant was to create a community-based Family Reunification Coalition whose goal was to reunify families through increasing the well-being, permanency, stability, and safety of children who are in out-of-home placement or are at risk out out-of-home placement as a result of a primary care giver's substance abuse. To accomplish these goals, the following system of services and supports were implemented and/or expanded: Family Treatment Drug Court, Rural

	Substance Abuse Services; Care Coordination; Matrix Model Substance Abuse Services; Social Work Services to Assist Respondent Parent's Counsel and their Clients; CASA Services; and Inter-agency Collaboration and Community Education through Executive Director for the Alliance for Drug Endangered Children. It was anticipated through taking a comprehensive view of families' situations, the Family Reunification Grant would reduce fragmentation of services, facilitate coordination of care, and increase treatment capacity.
Target Population	**The project targeted:** Families that met the following criteria: • The child or the parent/caretaker of any child who was living in the Fourth Judicial District and involved in the child welfare system due to substance abuse issues • Families were primarily identified by intake caseworkers investigating child abuse and neglect
Participants Served	Children: 582 Adults: 305 Families: 236
Major Goals	**Major program goals included:** • Children have permanency and stability in their living situations • Children are protected from abuse and neglect • The community has an increased ability to address parental and caretaker substance abuse and its affects on children • Families have enhanced capacity to provide for their children's needs
Key Major Program Services	**Case Management and In-Home Services** • Traditional Case Management • Family Group Decision Making • Traditional In-Home Services **Parenting/Family Strengthening** • Manualized Parenting Curriculum • Family Therapy Counseling **Substance Abuse Treatment for Adults** • Non-Intensive Outpatient – Matrix Model **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies

	• Co-location of Staff **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders **Family Treatment Drug Court**
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional County Welfare **Substance Abuse** • Substance abuse treatment agency/ providers **Courts** • Family Treatment Drug Court (FTDC) • Court Appointed Special Advocate (CASA) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Attorney • Drug Endangered Children (DEC) • Legal Services/Client Advocacy **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-Experimental Historical, Aggregate
Performance Indicators	**Recovery** There were a significant number of clients who completed treatment overall. In addition, being in therapy contributed to completing treatment. There were a significant number of clients who achieved abstinence at the end of their time in the program, both for primary substance and secondary substance. **Safety and Permanency** There was a significant effect of being in treatment on the child's living arrangement at beginning of the case. For FTDC, the effect was in the expected direction, with children being less likely to be out of the home.

	Well-Being For FTDC, being in that treatment group was associated with an improvement in child well-being, whereas not being in it was associated with a decrease (though insignificant) in child well-being, both measured from start to completion of treatment.
Sustainability Status	At the time of the Final Report, the team secured funding to continue to provide Family Treatment Drug Court for 7 of the expanded FTDC slots. Funding was secured by reallocating funds for other services to the expanded Family Treatment Drug Court slots previously funded by the Family Reunification Grant.
Project Director and Contact Information	Brandi Haws, Clinical Director 2864 Circle Dr, Suite 100 Colorado Springs, CO 80906 brandish@ppbhg.org
Project Evaluator and Contact Information	Michael Marting Director of Business Operations 6208 Lehman Drive, Suite 317 Colorado Springs, CO 80918 (719) 314-2531 Michael.marting@aspenpointe.org

Name of Lead Agency	**Hillsborough County Board of Commissioners**
Location	**Tampa, FL**
Title of Project	**Children's Reunification Services Collaborative**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Hillsborough County Congressional District 11
Brief Program Description	Children's Reunification Services Collaborative (CRSC) was designed to facilitate family reunification for children in out-of-home care in Hillsborough County who are affected by parental methamphetamine or

	other substance abuse. This project was designed to increase capacity for substance abuse treatment by providing additional slots for inpatient and outpatient drug treatment in the community. CRSC also offered additional supports to parent(s) as they sought the necessary treatment for their addiction through access to the Dependency System Navigators that included In-home supportive counseling for individuals, couples, and families; supportive and therapeutic visitation; and parenting instruction and reinforcement of skills once children had been returned to the home.
Target Population	**The project targeted:** Families that met the following criteria: • Parents in Hillsborough County experiencing meth and other substance abuse issues whose children had been removed from the home, but whose case plan called for reunification. • Children ages zero through 17, living in out-of-home care, whose case plans called for reunification.
Participants Served	Children: 157 Adults: 117 Families: 86
Major Goals	**Major program goals included:** The CRSC was created specifically to facilitate successful reunification for children in out-of-home care in Hillsborough County who were affected by parental methamphetamine or other substance use. By combining aggressive case management with increased availability of substance abuse treatment, the program sought to: • Improve timely access to appropriate level of substance abuse treatment • Reduce lengths of stay in foster care • Improve overall adult and child well-being by increasing stability of placement.
Key Major Program Services	**Case Management and In-Home Services** • Traditional Case Management • Intensive Case Management • Family Group Decision Making • Wraparound/Intensive In-Home Services • Traditional In-Home Services **Parenting/Family Strengthening** • Standard and Enhanced Parenting

	• Evidence-Based Parenting or Family Strengthening Program - Nurturing Parenting **Visitation Services** • Supportive Supervised Visitation **Family Therapy/Counseling** **Mental Health and Trauma** • Mental Health Services and Psychiatric Care • Trauma informed Services • Trauma-Specific Services - Seeking Safety, Addiction and Trauma Recovery Integration Model **Substance Abuse Treatment for Adults** • Residential/Inpatient Long-Term Matrix Model **Family-Centered Substance Abuse Treatment/Services** **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies -Motivational Interviewing/Motivational Enhancement Therapy, Contingency Management • Co-Located/Out Stationed Staff • Other Staffing Practice **Children's Services** • Mental Health Services for Children/Youth **Family Drug Court**
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare • Child Welfare Services Provider **Substance Abuse** • Substance Abuse Treatment Agency/Provider **Courts** • Family Treatment Drug Court (FTDC) • Law Enforcement/Legal/Related Organization • General Attorneys • Drug Task Force/Anti-Drug Coalition • Legal Services/Client Advocacy **Mental Health and Health Services**

	• Mental Health Services Providers • County Public Health • Adult Health Services • Children's Health Provider/Hospital • Dental Services **Housing** • State/County Housing Agency • Housing/Homeless Services Provider **Education** • County/Regional School District • Early Childhood Services/Education Provider • Parenting Education/Services Provider **Employment** • State/County Temporary Assistance for Needy Families (TANF) or Welfare Office • Employment Services Provider **Community and Child and Family Services** • Home Visiting Agency/Services Provider • Domestic Violence Services Provider/Agency **Evaluation or Training** • Evaluator (University-Affiliated or other) • Consultant/Training **Other** • State/County Agency- Children's Board
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level
Performance Indicators	**Safety** <u>Occurrence of child maltreatment:</u> Only 2% of children were victims of repeated maltreatment during the first six month period following enrollment. **Permanency** <u>Prevention of substance-exposed newborns:</u> In total, 86 women were served by the CRSC program over the course of the five years. Of those, six gave

	birth while involved in the program. All children were born substance-free. **Recovery** Access to treatment: In total, 115 adults received substance abuse treatment services as a result of participation in the CRSC. The median length of time between enrollment and entry into treatment was 13 days. Retention in substance abuse treatment: 51% of parents served completed their treatment at DACCO, the primary treatment provider participating in the CRSC. An additional 24% of the parents were transferred to another treatment program or facility. The average length of participation in treatment with DACCO was 202 days. **Well-Being** Parenting: Data was collected for 67 program participants using the Nurturing Parenting Program (NPP) measure of the Adult-Adolescent Parenting Inventory (AAPI), but matched pre- and post-test pairs were only available for 50 of the mothers. Of those, 82% demonstrated increased parental capacity as measured by that tool.
Sustainability Status	The Children's Reunification Services Collaborative (CRSC) was impacted by several contextual factors that impacted sustainability of the program including changes in lead child welfare agencies and an unstable fiscal landscape in the community. Although not sustained through an institutionalized approach, a Substance Abuse and Mental Health Services Administration (SAMHSA)-funded grant was received by the Family Dependency Treatment Court (FDTC) that would allow for the implementation of one Dependency System Navigator and continued treatment dollars to fund a step-down model.
Project Director and Contact Information	Tracy Iverson Hillsborough County Children's Services 3191 Clay Mangum Lane. Tampa, FL 33618 (813) 264-3807 iversont@hillsboroughcounty.org
Project Evaluator and Contact Information	Tampa Metro YMCA 110 E. Oak Ave. Tampa, FL 33602 (813) 924-5237

Name of Lead Agency	**Juvenile Justice Fund**
Location	**Atlanta, GA**
Title of Project	**Project Ready, Set, Go!**
Program Option	RPG 5-Year Grant (2007-2012); $500,000 annually
Geographic Area and Congressional District Served	Fulton County Congressional District 5
Brief Program Description	Project Ready, Set, Go! (PRSG) was implemented by the Juvenile Justice Fund (JJF) in collaboration with the Family Drug Court Program located in Fulton County, GA. Serving as a supportive service agency to Family Drug Court participants, PRSG was physically located in a space referred to as the "permanency center." PRSG staff utilized motivational interviewing as a method to continuously engage and assess clients' needs and provide referrals to appropriate service providers.
Target Population	**PRSG served:** • Addicted women who have children who have been maltreated or are "at risk" for maltreatment
Participants Served	Children: 312 Adults: 125 Families: 125
Major Goals	**Major program goals included:** • Ensuring that children are protected from abuse and neglect • Procuring permanency and stability in the living situation of children • Affirming that families have the enhanced capacity to provide for their children's needs, that the education, physical and mental health of the children are met and that children have the opportunity for healthy social and emotional development • Acquiring new or increased abilities to address the complex and compounding issues related to parental/caretakers' substance abuse and its effect on children
Key Major Program	**Case Management and In-Home Services**

Services	• Intensive Case Management **Family Therapy/Counseling Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing • Recovery Coach/Specialist • Co-location of Staff **Family-Centered Substance Abuse Treatment/Services Screening and Assessment – Substance Use and Other Adult Issues** • Specialized Screening and Assessment – Trauma, Domestic Violence **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma Informed Services **Family Treatment Drug Court**
Partner Agencies and Organizations	**Community-Based Family Services** • Atlanta Fulton – Family Connection Volunteer Lawyers Court Appointed Special Advocates **Child Welfare** • Department of Family and Children Services **Substance Abuse** • Fulton County Mental Health and Developmental Disabilities and Addictive Diseases • Mary Hall Freedom House • Metro Atlanta Recovery Residences • St. Jude's Recovery Center • Odyssey Family Counseling Center • My Sister's House • Fulton County Center for Hope and Rehabilitation **Education** • Literacy Action **Housing** • Advocates International Inc. • Department of Family and Children Services • Atlanta Housing Authority **Courts**

	• Fulton County Juvenile and Family Drug Court **Mental Health** • Fulton County Department of Mental Health, Developmental Disabilities and Addictive Diseases **Employment** • Atlanta Workforce Development **Other Community and Child and Family Services** • Atlanta Fulton-Family Connection • Volunteer Lawyers Court Appointed Special Advocates **Other** • Juvenile Justice Fund
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	**Recovery** Supportive Services: After successfully completing PRSG, a total of 48 families voluntarily entered aftercare services. PRSG expanded its aftercare program from a single psycho-educational group session held twice a month to a variety of alumni activities to engage and meet the interest and needs of the diverse participants graduating from PRSG. **Systems Collaboration** Cross-system collaboration: Data collected and analyzed over the course of five years suggested a growing partnership between JJF and Fulton County Juvenile Court as evidenced by an increase in engagement, participation and service delivery among participants enrolled in PRSG.
Sustainability Status	While the project was unable to sustain the social service agency, PRSG clients received supportive services onsite through the FDC. The FDC was able to sustain key components of the PRSG program including psycho-educational group sessions, case management and aftercare support. In addition, the FDC was able to obtain funding for human resources as a key need for the aftercare program. Funding was also obtained from Fulton County for a part-time clinician that will be used with aftercare and FDC.
Project Director and Contact	Kaffie McCullough, Deputy Director 395 Pryor St., Suite 2117, Atlanta, GA 30312 (404) 312-4520

Information	kmccullough@youth-spark.org
Project Evaluator and Contact Information	Dr. Quinn M. Gentry, Evaluator Emory University and Georgia State University quinn.gentry@team-moe.com

Name of Lead Agency	**Upper Des Moines Opportunity, Inc.**
Location	**Graettinger, IA**
Title of Project	**Parent Partners of NW Iowa Program**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Sioux City Region Congressional District 5
Brief Program Description	Three partners - Upper Des Moines Opportunity, Inc., the Iowa Department of Human Services-Sioux City Region and Juvenile Court Services-Third Judicial District - collaborated to build regional capacity in rural northwest Iowa. These three partners collaborated to increase access, availability and outreach to programs and services to increase the well-being of, permanency outcomes for, and enhance the safety of children who are in out-of-home or at risk of placement as a result of parent's or caretakers methamphetamine or other substance use.
Target Population	**The project targeted:** Families that met the following criteria: • Children living within the nine counties in rural Northwest Iowa (Buena Vista, Cherokee, Clay, Dickinson, Lyon, O'Brien, Osceola, Plymouth, and Sioux) who are in, or at-risk for an out-of-home placement due to methamphetamine or other substances by a parent/caretaker.
Participants Served	Children: 389 Adults: 267 Families: 201

Major Goals	**Major program goals included:** • Build Capacity: To demonstrate the organizational capacity to lead and champion a regional partnership to meet a broad range of children's needs for families involved in both the child welfare and the substance abuse systems. • Engage Parents: To offer an organizational environment that supports parent mentoring to assist other parents to navigate the child welfare system. • Integrate Services: To have increased capacity to support the individualized and diverse needs of families involved in the child welfare and substance abuse systems.
Key Major Program Services	**Case Management and In-Home Services** • Traditional Case Management • Family Group Decision Making • Wraparound/Intensive In-Home Services **Parenting/Family Strengthening** • Enhanced Parenting • Evidence-Based Parenting or Family Strengthening Program - Strengthening Families Program **Visitation Services** • Supervised Visitation • Supportive Supervised Visitation **Mental Health and Trauma Services for Adults** • Trauma Informed Services **Substance Abuse Treatment for Adults** • Intensive Outpatient - Matrix Model • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies - Motivational Interviewing/Motivational Enhancement Therapy • Peer/Parent Mentor • Co-located/Out Stationed Staff **Other Major Program Strategies** • Employment and Professional Development for Parent Partners **Family Treatment Drug Court**

Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency • Child Welfare Services Provider **Substance Abuse** • Substance Abuse Treatment Agency/Provider(s) **Courts** • Family Treatment Drug Court (FTDC) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Drug Endangered Children (DEC) **Other Community and Child and Family Services** • Peer/Parent/Mentor Group or network **Other Evaluation and Training** • Evaluator (University or Affiliated or Other) • Consultant/Training **Other** • Other State/County Agency (State Accreditation Technical Assistant)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level
Performance Indicators	The program did not include indicator data in the final report.
Sustainability Status	Funds were secured to continue Parent Partner mentoring services on a part-time basis in eight counties in FY 2012-2013. The site anticipates obtaining a permanent funding stream from the state Parent Partner rollout in FY 2013-2014.
Project Director and Contact Information	Lauri Carlson, Parent Partner Project Director UDMO P.O. Box 15 Okoboji, IA 51355 lcarlson@mchsi.com

Project Evaluator and Contact Information	Michelle Devlin, Evaluator University of Northern Iowa Center on Health Disparities- 107 HPC Cedar Falls, IA 50614 (319) 273-5806 michele.devlin@uni.edu

Name of Lead Agency	**Kansas Department of Social and Rehabilitation Services**
Location	**Topeka, KS**
Title of Project	**Kansas Serves Substance Affected Families (KSSAF) Project**
Program Option	RPG 5-Year Grant (2007-2012); $500,000 annually
Geographic Area and Congressional District Served	Kansas Statewide
Brief Program Description	The State of Kansas Social and Rehabilitative Services, Division of Children and Family Services, in partnership with eight State and local agencies, implemented a two-pronged approach to serving children affected by methamphetamine or other substance abuse. The two-pronged approach included: Having substance-affected families in the child welfare system at risk for child removal, or with the goal of reunification, participate in the evidence-based Strengthening Families Program (SFP) Integrating a web-based substance abuse prevention with existing life skills/independent living services for older youth in care and former foster care youth to reduce risk factors for substance use and increase resiliency
Target Population	**The KSSAF Project targeted:** • Families statewide, in all regions of service • Substance-affected child welfare population for whom reunification was the case plan goal through SFP

	• Older youth receiving life skills or independent living services with links to resources for independent living, ways to connect to other youth and information about alcohol and drug use through the Kansas Independence website to help youth make good decisions
Participants Served	Children: 367 Adults: 473
Major Goals	**Major program goals included:** • Decreasing substance use/misuse • Reducing the number of days to family reunification • Reducing future Child Protection Services child support investigations and reported and substantiated cases of child maltreatment • Decreasing parental use of excessive physical punishment • Increasing parenting knowledge, skills, supportiveness and efficacy • Increasing positive parent-child relationships, family organization and order, family communication skills and family strengths and resilience • Increasing the children's social and emotional competencies • Decreasing the children's social isolation, conduct problems and aggression • Measuring extent to which each visitor engage with the content on Kansas Independence website (number of pages visited, stories read, questions answered, etc.) as a way of evaluating participation
Key Major Program Services	**Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Strengthening Families Program **Substance Abuse Prevention Services** • Information Dissemination
Partner Agencies and Organizations	**Child Welfare** • Kansas Division of Children and Families • Community-based Contracted Child Welfare Service Providers **Substance Abuse** • Kansas Addiction and Prevention Services Division • Community-based Substance Abuse Treatment Agency **Evaluation and Training** • The University of Kansas School of Social Welfare • Lutra Group

	• In-depth Learning **Other** • Kansas Alliance for Drug Endangered Children
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Case-Level
Performance Indicators	**Permanency** Out-of-home Care: The typical SFP child participant spends 190 fewer days in out-of-home care than their non-SFP counterparts. For example, at the 360-day point from start of SFP, almost half (45.0 percent) of the SFP children were reunified, compared to 27.0 percent of the comparison children. **Family and Child Well-Being** Child Well-being: Statistically significant improvement was found in five areas of child outcomes. These areas included: • overt aggression • covert aggression • depression • concentration problems or reduced attention deficit • adjustments in social skills. Parenting: Evaluation of the SFP found the parents' level of depression and stress is reduced when the parents learned better parenting skills, spent more time with their children or saw improvements in their overall parenting abilities. Cost Savings: The local evaluation found that SFP saved approximately $16,340 per child in State and Federal out-of-home care costs.
Sustainability Status	At the time of the close of the grant, new privatization contracts were in process of rebidding and the continuation of SFP services became a requirement of the new contractors. As a result, SFP and the Kansas Independence website were both sustained. Evaluation results from SFP indicated that there was a reduction in time to reunification and significant cost savings.
Project Director and Contact Information	Susan Gile Kansas Department for Children and Families 915 SW Harrison, DSOB 5th Floor East, Topeka, KS 66610 (785) 296-5254

	susan.gile@srs.ks.gov
Project Evaluator and Contact Information	Tom McDonald, PhD University of Kansas, School of Social Welfare 1545 Lilac Ln, Twente Hall Lawrence, KS 66044 (785) 864-8959 t-mcdonald@ku.edu Jodi Brook, PhD University of Kansas, School of Social Welfare Edwards Campus, 12600 Quivira Rd. Overland Park, KS 66213 (913) 897-8554 jbrook@ku.edu

Name of Lead Agency	**Kentucky Department for Community Based Services**
Location	**Frankfort, KY**
Title of Project	**Kentucky Sobriety Treatment and Recovery Teams (K-Start for Martin County)**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Martin County Congressional District Statewide
Brief Program Description	Kentucky Sobriety Treatment and Recovery Teams (K-START for Martin County) was a Child Protective Services (CPS) initiated practice designed to address the co-occurrence of child maltreatment and parental substance abuse that paired specially trained CPS workers with Family Mentors (peer support specialists in recovery) in teams handling 12-15 cases. K-START partnered with substance abuse treatment providers to deliver intensive and comprehensive behavioral health treatment with quick access and retention supports. K-START was designed to keep children safe in permanent homes and nurture their wellbeing; to promote sobriety, recovery and parental capacity among substance-abusing parents; and to build community capacity

	for recovery supports.
Target Population	**The project targeted:** Families that met the following criteria: • Families with substantiated abuse and neglect • Substance abuse as a risk factor • At least one child three years of age or younger in the family • Family does not have an open CPS case • Referred from the CPS intake team within 30 days of the CPS report.
Participants Served	Children: 153 Adults: 128 Families: 67
Major Goals	**Major program goals included:** • Increase parents' access, retention and engagement in behavioral health treatment and community recovery supports and long-term well-being • Enhance the resources and coordination of resources for parents and children during the program • Improve the capacity of parents affected by substance abuse to care for their children's needs, promote their child's well-being and reduce child abuse potential • Keep children safe with their parents if possible, reunify families and promote attachment for children needing relative or foster care placements • Reduce the number of repeat referrals to Department for Community Based Services (DCBS) and recurrence of child abuse and neglect among families served • Enhance child developmental and emotional well-being
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Comprehensive Services **Engagement/Involvement of Fathers** • Targeted Outreach **Mental Health and Trauma Services for Adults** • Trauma-Informed Services

	• Trauma-Specific Services – Covington Programs, Helping Women Recover, Seeking Safety **Substance Abuse Treatment for Adults** • Aftercare/Continuing Care/Recovery Community Support Services – Matrix Model **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing • Peer/Parent Mentor • Co-location of Staff **Family-Centered Substance Abuse Treatment** **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Psycho-Social, Health/Medical
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/County Child Welfare Agency • Child Welfare Services Provider(s) **Substance Abuse** • Substance Abuse Treatment Agency • State Substance Abuse Agency • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Providers **Courts** • Other Dependency Court • Office State Courts Admin/Court Improvement Program (CIP) **Law Enforcement/Legal/Related Organization** • Other Drug Task Force/Anti-Drug Coalition **Mental Health Services and Mental Health Services** • State Mental Health Services • Regional/County Mental Health Services • Mental Health Services Provider • County Public Health **Housing**

	• Housing/Homeless Provider **Education** • County/Regional School District • College or University • Parenting Education/Services Provider **Employment** • State/County Employment Agency • State/County Temporary Assistance for Needy Families (TANF) or Welfare Agency **Other Evaluation and Training** • Evaluator (University-Affiliated or Other) **Other Community and Child and Family Services** • Domestic Violence Service Provider • Peer/Parent/Mentor Group of Network • Community Level District • Other Advisory/ Council Groups
Evaluation Design and Comparison Group Type	Quasi-experimental Historical, Matched Population-Level
Performance Indicators	**Safety** Recurrence of Maltreatment: Children served in Martin County were more likely to be placed out of the home compared to other K-START clients, however they experienced less recurrence of child abuse and neglect with a 6 month rate of recurrence at 4.6% compared to 10.1% in the matched control group and 5.1% for all other K-START sites. In 2007, the rate of recurrence in six months in Martin County was 25%; it is now 9.35%. **Permanency** Re-entry to Foster Care: Kentucky's overall rate of reentry to out-of-home care (OOHC) varied at about 13% within 12 months (CFSR Data Profile). Martin County has a rate of 0% at this time with the matched control group rate at 17.6% reentering OOHC in 12 months. **Recovery** Access to Treatment: The K-START treatment provider, MCCC, progressed from assessing 41% of clients (2008) to assessing 80% of clients within 3 calendar days of the referral. By 2011 MCCC was able to assess 68% of

	adults the same day as the referral. The rates of achieving sobriety have fallen in all K-START sites, corresponding to a threefold increase in the number of clients with opiate addiction which has always been highly prominent in Martin County (80% of parents with opiate addiction).
Sustainability Status	Recovery support groups, town hall meetings, PAR and other community recovery supports will be continued and changes to the culture will be ongoing in Martin County. Mentor services modeled after K-START will be provided with a preference to the highest risk cases. Although changes to the duration and intensity of mentor and treatment services were made, the changes have resulted in sustainable resources for families in the community. Clients will be assessed for service needs including new services such as Victim Services for people with trauma histories. Transportation will be available using the vehicle(s) purchased by the grant for clients who request it.
Project Director and Contact Information	Tina Willauer, K-START Director Sobriety Treatment and Recovery Teams Department For Community Based Services 275 E. Main St Frankfort, KY (502) 229-4053 Tinam.willauer@ky.gov
Project Evaluator and Contact Information	Ruth Huebner, Child Welfare Researcher Kentucky Department for Community Based Services 275 E. Main St Frankfort, KY (502) 229-4053 Rutha.huebner@ky.gov

Name of Lead Agency	**White Earth Band of Chippewa**
Location	**White Earth, MN**
Title of Project	**White Earth Band of Ojibwe, Indian Child Welfare Program**
Program Option	RPG 5-Year Grant; $500,000 annually

Geographic Area and Congressional District Served	Becker County Congressional District 7
Brief Program Description	The White Earth Child Well-Being Project served the area of the White Earth Reservation and 25 miles beyond its borders. The objectives were: • To build systems collaboration and improve treatment linkages between the tribal and Becker County Human Services programs • To create a culturally competent strategy for improving the well-being of White Earth's Native American children with caregivers who abuse substances with a focus on improving permanency outcomes for children at risk of, or in out-of-home placements • Provide substance abuse treatment and services to caregivers and their children in a rural area well-documented with highest rates in poverty, alcohol and drug abuse including methamphetamines, and suicide. • The project approach was to provide culturally appropriate, comprehensive strategy with multi-disciplinary human services program partnerships, targeted media educational delivery, and substance abuse treatment services designed to address the treatment needs and out-of-home placement issues experienced by White Earth caregivers and their children. Results of this project filled the gap and need for counseling and support services a year with substance abuse issues and who may or may not be involved with the Indian Child Welfare Program. Children directly at risk for, or in out-of-home placement received an array of services from seven or more multi-disciplinary partners in an integrated collaboration to improve permanency outcomes. Educational print information on substance abuse and methamphetamine reached all communities on the White Earth Reservation to provide education and improved understanding of the negative effects of substance abuse on families and community.
Target Population	**The project targeted:** • 50 caregivers/year and 125 children
Participants Served	Children: 411 Adults: 228 Families: 182
Major Goals	**Major program goals included:** Improve Well Being and Permanency - Participants will:

	• Understand effects substance abuse • Follow a healthy diet and exercise program • Access and receive appropriate treatment • Know how to access help • Understand how community involvement reduces • Maltreatment • Have support network • Support sobriety • Know how to access formal support networks
Key Major Program Services	**Case Management and In-Home Services** • Intensive Case Management • Family Group Decision Making • Wraparound/Intensive In-Home Services **Parenting/Family Strengthening** • Evidence-Based Parenting or Family Strengthening Program- Positive Indian Parenting **Substance Abuse Treatment for Adults** • Intensive Outpatient • Aftercare/Continuing Care/ Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Co-located of Staff • Culturally Responsvie- Wellbriety Approach **Family-Centered Substance Abuse Treatment/Services** **Substance Abuse Prevention Services** • Information Dissemination • Prevention Education **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Other Specialized Child Screening and Assessment - Mental Health/Psychological **Screening/Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Abuse Disorders • Other Specialized Adult Screening and Assessment

	Children's Services • Early Intervention **Housing Services** • Housing Support Services **Cross-Systems Collaboration** • Clinical and Program Training • Cross-systems Policies and Procedures • Regular Joint Case Staffing Meetings • Co-location of Staff • Cross-systems Information Sharing and Data Analysis
Partner Agencies and Organizations	**Substance Abuse** • White Earth Substance Abuse Program **Courts** • Family Treatment Drug Court (FTDC) • Other Dependency Court **Tribal** • White Earth Indian Child Welfare • Minnesota Tribal Child Welfare Consortia • White Earth Tribal Court • White Earth Family Drug Court • Tribe/Tribal Consortium **Criminal Justice, Law Enforcement, Legal and Related Organizations** • White Earth Tribal Law Enforcement • Anishinaabeg Legal Services • Tribal and area Attorneys • County Law Enforcement Agencies (Becker, Mahnomen, Clearwater) • Local Law Enforcement (police, sheriff) • Attorneys **Mental Health and Health Services** • White Earth Tribal Mental Health • Indian Health Services Clinic, White Earth • Area mental health provider agencies and counties

	Housing • Housing/homeless services provider **Education** • Individual School(s) Circle of Life Academy, White Earth (BIA School) • Pine Point Elementary School, Ponsford, MN (on reservation) • Naytahwaush Charter School • Neighboring School Districts: Waubun-Ogema Public • Schools, Mahnomen Public Schools, Detroit Lakes Public • Schools, Bagley Public Schools, Park Rapids Public Schools • Early Child Services/Education Provider White Earth Child Care & Early Childhood Initiative **Other Community and Child and Family Services** • State/County Temporary Assistance for Needy Families or Welfare Office • Home Visiting Agency/Services Provider White Earth Home • Health/Tribal Public Health Program **Other** • Church/Faith-Based Org • Domestic Violence Services Provider/agency • Evaluator (university-affiliated or other)
Evaluation Design and Comparison Group Type	Pre-experimental No group
Performance Indicators	The program did not include performance indicators in the final report.
Sustainability Status	The program did not include sustainability data in the final report.
Project Director and Contact Information	Jeri Jasken, Director PO Box 358 White Earth, MN 56591 (218) 983-4647 Jeri.jasken@whiteearth.com

Project Evaluator and Contact Information	Cyndi Anderson, Evaluator 1106 Washington Avenue Detroit Lakes, MN 56501 (218) 847-4257 cyndi@mosaicconsultinginc.com

Name of Lead Agency	**St. Patrick Center**
Location	**Louis, MO**
Title of Project	**Project Protect**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	St. Louis and County Areas Congressional District 1
Brief Program Description	Project Protect aimed to enhance the safety and wellbeing of children by enabling them to be reared by their parents in stable, nurturing home environments, away from the influences of substance abuse. Project Protect provided a comprehensive continuum of care for homeless and impoverished families with children in out-of-home placements or at risk of being removed from homes due to parental substance abuse. It uses the evidence-based practice, Intensive Case Management (ICM).
Target Population	**The project targeted:** Families that met the following criteria: • Families at risk of having their children removed from homes or have children in foster or substitute care with substance-abuse issues or co-occurring disorders and the dependent children involved in St Louis City and County areas.
Participants Served	Children: 813 Adults: 341 Families: 340
Major Goals	**Major program goals included:**

	• Children at risk of out-of-home placements due to parental substance abuse will remain with their parents • Children in out-of-home placements due to parental substance abuse will be returned to their parents • Substance-abusing parents will end or reduce their use of substances • Parents will address their behaviors that affect child wellbeing • Children will have opportunities for healthy physical, social and emotional development • Interagency collaborations will be improved to enhance permanency outcomes.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Traditional In-Home Services **Substance Abuse Treatment for Adults** • Intensive Outpatient – Matrix Model **Specialized Outreach, Engagement & Retention** • Motivational Interviewing **Family-Centered Substance Abuse Treatment** **Screening/Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment - Parenting, Psycho-Social **Housing Services** • Housing Support Services and Assistance • Permanent Supportive Housing and Permanent Housing **Other Major Program Strategy** • Transportation
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency **Substance Abuse** • Substance Abuse Treatment Agency **Courts** • Family Treatment Drug Court (FTDC)

	Mental Health Services • Mental Health Services Provider • Adult Health Services Provider (Hospital) **Housing** • Housing/Homeless Provider **Education** • State Department of Education • College or University **Other Evaluation and Training** • Evaluator (University-Affiliated or Other) **Other Community and Child and Family Services** • Church/ Faith-based Organization • Other Community Stakeholder Groups • Other Advisory/ Council Groups
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	Project Protect clients on average spent 277 less days in foster care than the average State of Missouri case, with a range from 18 to 567 fewer days. At a daily reimbursement rate of $227.00 the average Project Protect case saved the State of Missouri $51,680.00.
Sustainability Status	Within St. Patrick several products developed and implemented for the Project Protect Program are now used across programs of the Housing Department. The agency now examines outcomes of safety, permanency and wellbeing in Individualized Service Strategies (ISS) plans.
Project Director and Contact Information	Beverly C. Austin St. Patrick Center 800 N. Tucker Blvd St. Louis, MO 63101 (314)269-5043 (314)269-5048 Fax baustin@stpatrickcenter.org
Project Evaluator and	Mark Tranel, Director Public Policy Research Center

Contact Information	University of Missouri-St. Louis (314)516-5273 MTranel@umsl.edu

Name of Lead Agency	**Apsaalooke Nation Housing Authority (ANHA)**
Location	**Crow Agency, MT**
Title of Project	**Meth Free Crowalition (MFC)**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Crow Indian Reservation Congressional District 1
Brief Program Description	The Apsaalooke Nation Housing Authority's (ANHA) Meth Free Crowalition (MFC) was designed as a community prevention program for the purposes of providing alternative activities, particularly aimed at youth. One of the successful elements of the project was the effective collaboration between local tribal programs and also resulted in staff co-location with these partners. This maximized available services to children and their families and promoted further inter-agency collaboration. Sharing of clients and services allowed the Regional Partnership Grant (RPG) and the partners to provide additional parenting, youth outreach, equine therapy, and other vital prevention services to address methamphetamine and other drug related concerns. Since the RPG grant was a prevention/early intervention project (as opposed to a full service child welfare project) these partnerships allowed the project to gather data and participate in the national cross-site evaluation. The RPG, building upon the work initiated by the "Meth Free Crowalition," located in Crow Agency, Montana, established the first "Crow Nation Office of Methamphetamine and Substance Abuse Prevention" for the delivery of Methamphetamine and Substance Abuse intervention (e.g., Parenting classes, reunification services for those parents whose children have been removed, treatment plans for those families assessed, home visits, culturally-appropriate treatment, etc.) and prevention (e.g., drug awareness, community anti-meth walks, cultural activities, after school programs and community activities) services for children and adolescents and their families on the Crow Indian Reservation, located in South-Central Montana. These efforts

	were based on the grass-roots work by the community, which morphed into the Apsáalooke Meth Prevention Office (AMPO) upon receiving funds from the Regional Project Grant (RPG) program in 2007.
Target Population	**The project targeted:** • The prevention service population on the Crow Reservation is approximately 10,000 tribal members plus several thousand non-enrolled spouses and children of members.
Participants Served	Children: 572 Adults: 635 Families: 761
Major Goals	**Major program goals included:** The over-arching goal of the MFC was to decrease the prevalence of substance abuse, particularly methamphetamine. The goal was prevention rather than intervention in nature. • To provide a minimum of 30 prevention activities per year servicing at least 400 youth per year in the seven reservation community districts (6 on reservation and 1 off reservation) as measured by participant records, performance indicators, sign in sheets, surveys and internal and external evaluation results. • The Meth Free Crowalition has developed an Apsáalooke Junior Police Academy Program to provide leadership, meth education, cultural enhancement, self-esteem, vocational skills, physical and emotion development. The JPA will service at least 50 youth per year. Academy will continue advanced training and incentive activities throughout the year for continued support to cadets. • The Meth Free Crowalition will establish at least 8 partnerships to collaboratively identify and maximize resources to promote wellness (including cultural, spiritual, physical and emotional well being), education and prevention activities as well as supplement existing family based service & support systems of the Apsáalooke Nation as measured by MOA's executed, complete CCI instrument annually, resources identified, and internal and external evaluation results. • At a minimum (3) staff will be co-located at least 2 days per work week at Healing to Wellness, Tribal Court, Tribal Health and Human Services and Tribal Social Services to improve collaboration and minimize gaps in services. • The Meth Free Crowalition will develop a common intake form to develop a centralized tribal data collection system, which will strengthen the data gathering process with the local partners.

	• The Meth Free Crowalition developed a local level evaluation plan to identify and/or create instruments and tools to identify the effectiveness of the program, strengths and weaknesses in program. • The Meth Free Crowalition, in collaboration with the eight identified partners, will develop a sustainability plan that will allow the continuation of prevention activities in all six reservation community districts beyond the period of Federal funding. Partners that have committed to the sustainability plan include; Indian Country Meth Initiative, HIV/AIDS, Tribal Systems of Care, Tribal Social Services, Tribal Health and Human Services, Drug Enforcement Division, and Tribal Healing to Wellness Youth Diversion program. The first draft for the sustainability plan to be completed in cooperation with partners, November 15, 2010 and final to be completed by March, 2011. • The Meth Free Crowalition will adapt the NCAI Meth Tool Kit ("healing bags") for the Crow youth and families as an educational preventative curriculum to be utilized at each local school, community meetings, the Crow Junior Police Academy Camps, Crow cultural events, and other collaborative activities throughout the year.
Key Major Program Services	**Case Management and In-Home Services** • Traditional Case Management • Traditional In-Home Services **Parenting/Family Strengthening** • Evidence-Based Parenting or Family Strengthening Program - Positive Indian Parenting Crow Style **Substance Abuse Treatment for Adults** • Non-Intensive Outpatient **Specialized Outreach, Engagement and Retention** • Co-located Out Stationed Staff • Cultural Support Services **Substance Abuse Prevention Services** • Information Dissemination and Education • Alternative Activities • Problem Identification and Referral • Community-Based Process • Environmental Approaches **Screening and Assessment** • Screening/Assessment for Child Welfare Issues

	Cross-Systems Collaboration • Clinical Program Training • Cross-systems policies/procedures • Regular Joint Case Staffing • Co-location of Staff • Cross-systems information/data Sharing • Partner Meetings **Other** • Provide Ancillary Support Services to Tribal Court Youth Diversion Program Participants
Partner Agencies and Organizations	**Courts** • Family Treatment Drug Court (FTDC) • Juvenile Justice Agency **Tribal** • Tribal Child Welfare Agency/Consortia Tribal Child Welfare • Tribal Substance Abuse Agency • Tribal Court • Tribe/Tribal Consortium **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Local Law Enforcement **Other Community and Child and Family Services** • Home Visiting Agency/ Services Provider • Other Child/Family Services Provider • Church/Faith-Based Organization • Peer/Parent/Mentor Group or network • Other Community Stakeholders **Other Evaluation and Training** • Evaluator (University or Affiliated) • Consultant/Training **Other** • Other State/County Agency (State Accreditation Technical Assistant)
Evaluation	Pre-experimental

Design and Comparison Group Type	
Performance Indicators	**Safety** Those identifying safety as a problem (serious, moderate, or mild) decreased from almost 31% at the baseline to approximately 19% at conclusion. This reflects a growth in a perception of public safety over time. However, the overall environment score increased from 9.2% to 12.8% identifying it as a problem. **Parenting** This trend continues throughout the overall domain scores where the problems have actually increased over time, at least as perceived by the participants. However, due to all of the issues with the data and its collection, the validity of and consistency of the data cannot be verified.
Sustainability Status	The RPG was only able to sustain specific parts of the program which and several of these may not be sustained as many of the tribal administrators supervising services were terminated. As a new administration and new key staff members came into office, the momentum with key stakeholders was lost. As a result, the sustainability of some activities remain in question. The following programs were sustained by either new funding or through absorption into partner program operations: • Junior Police Academy was sustained through Department of Justice Tribal Youth Program funding • Equine Therapy was sustained through Department of Justice Tribal Youth Program funding • Youth diversion was integrated into the Tribal Courts operations • The family-based assessment North Carolina Family Assessment Scale (NCFAS) was intended to be integrated within operations of partner entities. However, it is unclear if that was actually sustained • School-based programs were integrated within the schools • Community based prevention activities were sustained • through grassroots community members, as they operated prior to RPG funding.
Project Director and Contact Information	Ms. April Toineeta Apsáalooke (Crow) Nation Housing Authority Crow Indian Reservation P.O. Box 99 1 Circle Lane Crow Agency

	Montana 59022 (406) 638-7133 atoineeta@crowhousing.org
Project Evaluator and Contact Information	Jim Swan RJS & Associates, Inc.435 Oats Road Box Elder, MT 59521(406)395-4757 jimswan23@gmail.com

Name of Lead Agency	**Westchester County**
Location	**White Plains, NY**
Title of Project	**Westchester County Department of Community Mental Health**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	County of Westchester Congressional District 18
Brief Program Description	The project focused on adding child welfare expertise and resources to our network of chemical dependency treatment providers. Westchester has 1,487 children receiving Prevention Services but over 3,000 living with adult substance abusers in treatment. We provided substance abuse counselors treating those adults the training and tools needed to screen children for serious emotional disturbances or developmental delays, and link children to Networks we've created that help families access the complex array of services available through child welfare, children's mental health, and special education systems. The project add long-team intensive case management and short-term transitional case management for substance-affected families with children with serious emotional disturbances or developmental delays. This will allow us to: • Reach many more at-risk children • Mobilize hundreds of professionals who have the most consistent contact with the adult substance abusers to help screen high-risk children for emotional disturbances, unmet special education needs and developmental delays

	• Intervene earlier, providing preventive and/or family stabilization services before children are placed in foster care or suffer tragic consequences.
Target Population	**The project targeted:** High-need families of substance-abusing parents with young children at risk of entering foster care and who have one or more children with complex mental health, developmental or special education needs Provide long-term intensive clinical case management for caseload of at least 50 families per year
Participants Served	Children: 699 Adults: 427 Families: 344
Major Goals	**Major program goals included:** • Reach more at-risk children • Mobilize hundreds of professionals who have the most consistent contact with adult substance abusers to help screen high-risk children for emotional disturbances, unmet special education needs, and developmental delays • Intervene earlier, providing preventive and/or family stabilization services before children are placed in foster care.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Comprehensive Services **Parenting/Family Strengthening** • Standard Parenting Skills Training • Evidence-Based Parenting or Family Strengthening Program – Strengthening Families Program **Mental Health and Trauma Services for Adults** • Psychiatric Care Including Medication Management • Trauma-Informed Services – Seeking Safety **Substance Abuse Treatment for Adults** • Intensive Outpatient • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention**

	• Cognitive Behavioral Strategies – Motivational Interviewing • Recovery Coach/Specialist • Co-location of Staff **Family-Centered Substance Abuse Treatment Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Screening and Assessment for Trauma • Other Specialized Child Screening and Assessment – Mental Health/Psychological, Developmental **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Mental Health/Co-Occurring Disorders, Parenting **Children's Services** • Early Intervention • Mental Health Counseling • Trauma Services for Children/Youth - Child Interaction Therapy (PCIT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Sanctuary Model **Cross-Systems/Interagency Collaboration** • Clinical and Program Training • Cross-systems Policies and Procedures • Regular Joint Case Staffing Meetings • Co-location of Staff • Cross-systems Information Sharing and Data Analysis • Partner Meetings **Housing Services** • Housing Support and Assistance Services
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency • Child Welfare Services Provider **Substance Abuse** • State Substance Abuse Agency • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Provider

	Courts • Family Treatment Drug Court (FTDC) • Adult Drug Court • Mental Health Court **Health Services** • Regional County Mental Health Agency • Mental Health Services Provider **Other Evaluation and Training** • Evaluator (University or Affiliated or Other) • Consultant/Training
Evaluation Design and Comparison Group Type	Quasi-experimental Historical Matched Population-Level Usual Child Welfare/Substance Abuse Services
Performance Indicators	The program did not include indicator data in the final report.
Sustainability Status	Able to sustain specific components/scaled down version of program model. Westchester County Department of Community Mental Health staff will continue to monitor compliance of children's mental health screening and family functioning surveys. Family Network will continue to function within the substance abuse system for higher need families who are experiencing problems negotiating multiple systems of care. Intensive Case Management requires designated funding to continue and will not be sustained.
Project Director and Contact Information	Dahlia Austin, Director 112 East Post Road, 2nd Floor White Plains, NY 10601 (914) 995-5010 Daa3@westchestergov.com
Project Evaluator and Contact Information	Thomas B Saunders, MPA NYU's Institute for Education and Social Policy (212) 260-6768 Tom.Saunders@nyu.edu

Name of Lead Agency	**Butler County Children Services (BCCS)**
Location	**Hamilton, OH**
Title of Project	**Child Abuse and Neglect Substance Abuse Focus and Expansion (CANSAFE)**
Program Option	RPG 5-Year Grant (2007-2012);$500,000 annually
Geographic Area and Congressional District Served	Butler County Congressional District 8
Brief Program Description	Butler County Children's Services implemented two treatment models or approaches – The Family Drug Court (FDC) and the Multidisciplinary Treatment Team (MDTT) – to address the county's outcome gaps. The major goal of CANSAFE was to closely match the county's outcomes to the established national standards on removal, reunification, recurrence and reentry rates. To accomplish this goal, service gaps were identified and included: 1) lack of family-focused and substance abuse related group intervention that includes children; 2) lack of understanding of substance abuse issues by kinship and foster caregivers; 3) insufficient residential, intensive outpatient and outpatient substance abuse treatment; 4) lack of case management; and, 5) insufficient attention to ancillary and after-care needs.
Target Population	**CANSAFE targeted:** • Families with substance abuse by a caregiver as the primary contributor of child maltreatment and assessed to be in need of ongoing services beyond the investigation • Families with open child welfare cases who had children at risk of placement, in paid placement and kinship care, as well as those who remained in their own homes • The program excluded families receiving services through the Alternative Response pathway.
Participants Served	Children: 230 Adults: 216 Families: 127
Major Goals	**Major program goals included:**

	• Reducing the number of removals • Increasing the number of safe reunifications • Reducing the reoccurrences of child maltreatment • Reducing the number of reentries into BCCS custody • Increasing parents' successful substance abuse treatment outcomes • Decreasing parents' use of substances • Increasing well-being of children • Increasing family functioning
Key Major Program Services	**Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Celebrating Families! **Mental Health and Trauma Services for Adults** • Mental Health Services and Psychiatric Care • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Specialized Outreach, Engagement and Retention** • Alcohol and Other Drugs Specialized Child Welfare Case Workers • Recovery Support Specialists
Partner Agencies and Organizations	**Child Welfare** • Butler County Children Services-Lead Agency **Substance Abuse** • Alcohol and Chemical Abuse Council of Butler County • Butler County Alcohol and Drug Addiction Services Board • Sojourner Recovery Services • The Next Right Thing **Courts** • Butler County Juvenile Court **Mental Health** • Butler County Mental Health Board • Children's Diagnostic Center • Community Behavioral Health **Employment** • Butler County Department of Job and Family Services **Other Evaluation and Training**

	• Miami University
Evaluation Design and Comparison Group Type	Experimental Randomized Control Group
Performance Indicators	**Safety** Out-of-home Care: The MDTT group had the lowest rate of placement into foster care, 13.4 percent, as compared to 27.6 percent for the control group and 32.1 percent for the FDC group. **Child and Family Well-Being** Family Relationships and Functioning: Using the Protective Factors Survey, the evaluation revealed improvement in several domains for participants. For example, parents in the MDTT treatment group experienced increases in adaptive skills and strategies related to open communication, acceptance and problem solving and management. Parents in the FDC group also demonstrated improvement in Family Social Emotional Support and Nurturance. **Recovery** Treatment Completion: The FDC group had the highest percentage of successful substance abuse treatment completion at 55.0 percent, compared to 32.3 percent for the MDTT group and 26.0 percent for the control group. Substance Use: FDC participants significantly reduced their use of substances including alcohol, cocaine, marijuana and heroin. Similarly, the results for the MDTT group indicated statistically significant reductions for MDTT participants in their use of three of the commonly used substances including, cocaine, marijuana and heroin.
Sustainability Status	BCCS was able to maintain the component of the RPG program identified as the Substance Abuse Assessor/Utilization Review Manager. This position continued as an employee of BCCS and assists clients in receiving the most appropriate and timely treatment possible. Additionally, local capacity for collaboration was built and led to more sharing of resources and more effective communication between treatment providers and related agencies and governing bodies.
Project Director and Contact Information	Donna Lang Butler County Children Services Board 300 N. Fair Ave. Hamilton, OH 45011 (513) 785-5906 langd01@odjfs.state.oh.us

Project Evaluator and Contact Information	Kevin Bush Miami University Oxford Family Studies and Social Work 101 McGuffey Hall Oxford, OH 45056 (513) 839-5097 bushkr@muohio.edu

Name of Lead Agency	**Choctaw Nation of Oklahoma**
Location	**Durant, OK**
Title of Project	**Serving Our At-Risk (Project SOAR)**
Program Option	RPG 5-Year Grant (2007-2012); $500,000 annually
Geographic Area and Congressional District Served	Latimer County, Pittsburg County and McCurtain County Congressional District 2
Brief Program Description	The mission of Serving Our At Risk, also known as Project SOAR, was to increase interagency collaboration and integration of programs and services by providing evidence-based and culturally sensitive activities and services. The project's activities and services were designed to increase the well-being of, increase permanency outcomes for and enhance the safety of children who are in out-of-home placement or are at risk of being placed in out-of-home care as a result of a parent's or caretaker's methamphetamine or other substance abuse in Latimer, Pittsburg and McCurtain Counties in south-eastern Oklahoma.
Target Population	**Project SOAR:** • Served families whose children were in out-of-home placement or were at risk of being placed in an out-of-home placement as a result of a parent's or caretaker's methamphetamine abuse • Provided services to three county drug courts
Participants Served	Children: 100 Adults: 169

	Families: 146
Major Goals	**Major program goals included:** • Building the region's capacity to meet a broad range of needs for families involved with both substance abuse treatment and the child welfare system by improving interagency collaboration and integration of programs serving children who are in an out-of-home placement as a result of a parent's or caretaker's methamphetamine or other substance abuse • Providing intensive outpatient counseling services for at-risk children and their families, as well as securing support from other resources for additionally identified needs • Providing sessions of the nationally-acclaimed Strengthening Families Program for at-risk children and their parents or caretakers • Providing the evidence-based Lions-Quest curriculum for at-risk elementary school aged children attending school in Latimer and Pittsburg counties
Key Major Program Services	**Case Management and In-Home Services** • Family Group Decision Making/Family Case Conferencing **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Strengthening Families Program **Engagement/Involvement of Fathers** **Mental Health and Trauma Services for Adults** • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety, Wellbriety **Substance Abuse Treatment for Adults** • Long-Term Residential/Inpatient • Residential/Inpatient – Specialized for Parents with Children • Intensive Outpatient – Matrix Model **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies **Substance Abuse Prevention Services** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Trauma • Specialized Screening and Assessment – Psychosocial

	Children's Services • Early Intervention and Developmental Services • Mental Health Services for Children/Youth • Trauma Services for Children/Youth – Parent-Child Interactive Therapy (PCIT) **Housing Services** • Housing Support and Assistance Services
Partner Agencies and Organizations	**Child Welfare** • Choctaw Indian Child Welfare Department • Oklahoma Department of Human Services (State Child Welfare department) **Substance Abuse** • Choctaw Nation Inpatient Treatment Programs **Courts** • Oklahoma County Drug Courts (Pittsburg, Latimer and McCurtain Counties) **Tribal** • Choctaw Community Health Representatives **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Choctaw Law Enforcement **Mental Health** • Choctaw Behavioral Health & Substance Abuse Prevention **Health Services** • Choctaw National Health Services Authority **Housing** • Choctaw Housing Authority **Education** • Choctaw Education Department **Employment** • Choctaw Tribal TERO Program **Other Community and Child and Family Services** • Choctaw Women, Children & Infants Program **Other Evaluation and Training**

	Other • 18 School Districts
Evaluation Design and Comparison Group Type	Pre-experimental
Performance Indicators	**Permanency** Reunification: The program was successful in reuniting 70.0 percent of the children who were in out-of-home care. All of these children had been removed from the home prior to program intake. **Recovery** Access to Substance Abuse Treatment: All of the adults received substance abuse treatment and treatment at the level for which they were assessed. Treatment Completion: More than three-quarters (77.5 percent) of adults completed treatment.
Sustainability Status	The program has been able to sustain a number of services offered through the grant including mental health services (e.g., individual, marriage, family and group therapy). They have also sustained outpatient substance abuse services offered by counselors who are available in the northern and southern boundaries of the counties served. The site also reported that their work with the drug courts have been institutionalized and that they will continue this collaborative relationship and will also continue to develop their relationship with probation and parole. Additionally, by addressing the Oklahoma State Child Welfare Improvement Plan Pinnacle Points in the development of the RPG program, the site was able to improve their ability to access and sustain Medicare funding.
Project Director and Contact Information	Karen Hearod, Project Director 1317 South George Nigh Expressway McAlester, OK 74501 (918) 424-5053 kehearod@cnhsa.com
Project Evaluator and Contact Information	Barbara Plested, Evaluator Choctaw Nation of Oklahoma 25281 S. 610 Dr. Grove, OK 74343 bplested@aol.com

Name of Lead Agency	**Oklahoma Department of Mental Health and Substance Abuse Services**
Location	**Oklahoma City, OK**
Title of Project	**Oklahoma Partnership Initiative**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Oklahoma County Congressional District 5
Brief Program Description	The Oklahoma Partnership Initiative (OPI) to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine and other substance abuse addresses the growing problem of children who are at high risk for substance abuse and other problem behaviors due to their parents' substance abuse. The goal of this project was to intervene effectively and early to prevent and reduce the risks for children associated with parental methamphetamine and/or other substance abuse.
Target Population	**The project targeted:** The Oklahoma Partnership Initiative (OPI) established unique target populations and eligibility criteria for each program component as follows: • Universal Screening component: All parents whose children are at imminent risk for removal due to child abuse or neglect (statewide); • Accessibility of services to newborns component: Health professionals who provide care to women, children and families (statewide) • Early intervention/prevention component: Out-of-home children aged 3-12, their primary caregiver, and their biological parent (statewide) and parents needing substance abuse treatment and their children (statewide)
Participants Served	Children: 157 Adults: 122 Families: 92
Major Goals	**Major program goals included:** To intervene effectively and early to prevent and reduce the risks for children associated with parental methamphetamine and/or other substance

	abuse. Objectives include: • Universal screening for alcohol and substance abuse for all parents whose children are at risk of removal in the child welfare system • Expanding the accessibility of services to substance exposed newborns through enhanced identification and intervention with infants identified as substance exposed. • Early intervention and prevention services for children and adolescents of substance abusing parents through evidence based programs. • Improvements in cross system information sharing mechanisms to ensure consistent data collection across the substance abuse and child welfare systems
Key Major Program Services	**Case Management and In-Home Services** • "Traditional" Case Management **Parenting/Family Strengthening** • Evidence-Based Parenting or Family Strengthening Program – Strengthening Families Program **Substance Abuse Treatment for Adults** • Intensive Outpatient – Matrix Model • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive and Behavioral Strategies – Motivational Interviewing **Family-Centered Substance Abuse Treatment** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Trauma • Other Specialized Child Screening and Assessment – Mental Health/Psychological, Behavioral/Socio-Emotional **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Parenting **Children's Services** • Early Intervention and Developmental Services • Mental Health Counseling • Trauma Services for Children/Youth **Cross-Systems/Interagency Collaboration** • Clinical and Program Training

	• Cross-systems Policies and Procedures • Cross-systems Information Sharing and Data Analysis • Partner Meetings
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/County Child Welfare Agency • Child Welfare Services Provider(s) **Substance Abuse** • State Substance Abuse Agency • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Provider(s) **Courts** • Family Treatment Drug Court (FTDC) • Juvenile Justice Agency (State/County/Local) **Criminal Justice, Law Enforcement, Legal and Related Organizations** • County Corrections **Mental Health and Health Services** • State Mental Health Agency • Mental Health Services Provider(s) • Children's Health Provider/Hospital **Education** • Parenting Education/Services Provider • State/County Temporary Assistance for Needy Families (TANF) or Welfare Office **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-time, Matched Population-Level Usual Child Welfare/Substance Abuse Services
Performance Indicators	Recent reporting prepared by the grantee targets the experiences with implementation of the UNCOPE. Latent class analysis was used to identify homogenous subpopulations within the larger foster care involved

	population; and to test if patterns existed within respondents who were are various degrees of risk for substance abuse.
Sustainability Status	OPI was able to sustain specific components of the project. Through the grant resources statewide Strengthening Families Program training was held to ensure that treatment providers were trained in the curriculum throughout Oklahoma and had the capacity to continue the services. In addition, the Strengthening Families Program is able to bill Medicaid for services, which allows for sustainability after the grant ends. OPI will also sustain use of the UNCOPE in child welfare cases involving children at risk or in out of home care as the screening is embedded in the Family Functional Assessment used by child welfare. The project will be able to sustain UNCOPE data collections without additional funding as OKDHS is fully committed to ensuring that the UNCOPE data set is electronically incorporated into the statewide computerized child welfare tracking system. OPI was not able to sustain the New Directions program component.
Project Director and Contact Information	Elicia G. Berryhill, M.A., Sr. Prevention Program Manager Oklahoma Department of Mental Health & Substance Abuse Services 1200 NE 13th Street P.O. Box 53277 Oklahoma City, Oklahoma 73152 (405) 522-0077 EBerryhill@odmhsas.org
Project Evaluator and Contact Information	Jody Brook, Ph.D, MSW/LCSW University of Kansas School of Social Welfare Edwards Campus 12600 Quivira Road, Suite 125 Overland Park, KS 66213 (913) 897-8554 jbrook@ku.edu

Name of Lead Agency	**Baker County/ Northeast Oregon Collaborative**
Location	**Baker City, Oregon**
Title of Project	**The Northeast Oregon Collaboration for Child Safety (NOCCS)**
Program	RPG 5-Year Grant; $500,000 annually

Option	
Geographic Area and **Congressional District Served**	Baker County Congressional District 2
Brief Program Description	The Northeast Oregon Collaborative for Child Safety (NOCCS) was a three county partnership focused on developing formal collaborations between the child welfare systems, substance abuse treatment and court systems in the three eastern Oregon counties of Baker, Union and Wallowa. The purpose of NOCCS was to promote child safety and permanency through increasing drug and alcohol, mental health and wrap around services to families. The intended families were those with children in an out of home placement or at risk of being placed in an out of home placement as a result of a parent's or caretaker's methamphetamine or other substance abuse. Additional goals included the increase of treatment services available to parents and caregivers; family centered treatment and the development of an integrated system of care in a region of the state that was significantly lacking in resources with no funding for expanding services. The RPG funding supported a project manager and six alcohol drug counselors. The NOCCS program engaged parents and care givers in substance abuse treatment, provided intensive case management, wrap around services, and linkage to mental health, medical and dental services. NOCCS clinicians worked alongside the state child welfare programs and courts, developing a joint services delivery system and unified case plans for families. NOCCS contracted with RMC Research in Portland Oregon to provide data management and data evaluation.
Target Population	**The project targeted:** • The NOCCS project specifically targeted services and supports to families with children in an out of home placement or at risk of out of home placement because of parent or caretaker's methamphetamine or other substance abuse. This tri county region of Baker, Union and Wallowa counties represents one of the most rural and remote areas of Oregon, covering an area of 8,308 square miles with a population across the three counties of approximately 47,5001 or .3 percent of the state's total population. Many families live 20-30 minutes from services and no public transportation is available. Unemployment and childhood poverty in this region is consistently higher than the state and national figures and the median household income is about 16 percent lower than state median.
Participants	Children: 843

Served	Adults: 494 Families: 494
Major Goals	**Major program goals included** • Benefit the well-being, permanency, and safety of children in the region. • Serve an additional 240 families annually with drug, alcohol, and mental health services. • Build upon and share the collective strengths of the individual service providers in the three-county region. • Increase the effectiveness of the existing drug courts. • Ensure continued and enhanced efficient and effective coordination between the Child Welfare System and the treatment providers.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Wraparound/Intensive In-Home Comprehensive Services **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety **Substance Abuse Treatment for Adults** • Intensive Outpatient – Matrix Model • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing, Moral Reconation Therapy • Co-location of Staff • NIATx **Family-Centered Substance Abuse Treatment** **Substance Abuse Prevention Services** • Information Dissemination and Education • Environmental Approach **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders

	• Other Specialized Adult Screening and Assessment – Family Functioning, Mental Health/Co-Occurring Disorders, Trauma/Domestic Violence, Health/Medical **Children's Services** • Mental Health Counseling **Cross-Systems/Interagency Collaboration** • Clinical and Program Training • Cross-systems Policies and Procedures • Regular Joint Case Staffing Meetings • Co-location of Staff • Cross-systems Information Sharing and Data Analysis • Partner Meetings
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/County Child Welfare Agency **Substance Abuse** • Regional/County Substance Abuse Agency • Community Based Substance Abuse Treatment Agency/Providers **Courts** • Adult Drug Court **Mental Health/Health Services** • Mental Health Services Providers • County Public Health-MCH • Managed Care Entity or FQHC **Education** • Early Childhood Council/Coalition **Other Community and Child and Family Services** • State/County Temporary Assistance for Needy Families (TANF) or Welfare Office • Other Child/Family Services Provider **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and	The evaluation team conducted both process and outcomes evaluation. The outcome evaluation includes descriptive statistics of quantitative variables,

<table>
<tr><td>Comparison Group Type</td><td>inferential statistics comparing decline in substance use for those in the NOCCS treatment sample with those in the comparison sample, and findings from a qualitative analysis. Data from the adults who participated in NOCCS substance abuse assessment and treatment services were successfully matched to state AMH data. Comparisons made between the NOCCS treatment sample and a comparison group was limited to data extracted from state data systems.

Comparisons related to child outcomes could not be completed because of problems with the State Child Welfare Data system, which resulted in an inability to collect data on children in the program for two of the four years and to identify a reliable comparison sample.</td></tr>
<tr><td>Performance Indicators</td><td>Safety

Occurrence of child maltreatment: Over the course of the grant period, 164 children had at least one disposition of an investigation or assessment of allegations of maltreatment. This constitutes approximately 19 percent of the 848 children of adults in the treatment sample. The majority of maltreatment episodes took place prior to adult entry into treatment (n = 167; 78 percent). Twenty maltreatment episodes took place in the first 6 months after treatment entry (9 percent), 10 episodes took place 6-12 months aft.

Permanency

Children remain at home: During the grant period, 132 of the 848 children (16 percent) of adult clients were placed into foster care at least once, while there was no record of removal for the remaining 712 children (84 percent).

Average length of stay in foster care and Timeliness of Reunification: While the grantee selected these indicators, the State Reunification and Foster Care Discharge Dates were not available.

Well-Being

Children assessed for supported services: Of the 436 parents/caregivers who participated in NOCCS treatment, child assessments for supportive services data were available for 435 clients—one child per client.

<table>
<tr><th>Supportive Service Type</th><th>Assessed</th></tr>
<tr><td>Medical/Dental care</td><td>82%</td></tr>
<tr><td>Mental health</td><td>68%</td></tr>
<tr><td>Substance abuse</td><td>69%</td></tr>
<tr><td>Attendance</td><td>59%</td></tr>
<tr><td>Education</td><td>58%</td></tr>
<tr><td>Behavior</td><td>77%</td></tr>
<tr><td>Juvenile justice</td><td>65%</td></tr>
</table>
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Recovery

Adult Indicators- Access to Treatment: Across all 452 treatment episodes with available AMH data, 440 had valid data regarding treatment assessment and entry dates. Of these, the average number of days between assessment and treatment entry was 2.5 days. The majority (*n* = 371; 84 percent) of treatment episodes began on the same day as the assessment, which suggests access to treatment was timely.

Retention in Substance Abuse Treatment: Of the 388 NOCCS clients treated and with available AMH data, 161 (41 percent) remained in treatment until it was completed.

Parents or Caregivers Connected to Supportive Services

Supportive Service Type	Assessed
Medical/Dental care	90%
Mental health	83%
Child care	74%
Transportation	90%
Housing assistance	90%
Parenting	85%
Domestic violence services	86%
Education	88%
Employment	83%
Public assistance	85%
Finance	90%
Criminal Justice	84%

Sustainability Status

The treatment agencies sustained three of their six Substance Abuse Specialists post-grant funding. They were not able to sustain the wraparound funding, which was identified as one of the most critical elements of services for families. However, all three counties continue to collaborate to serve families in this region and report that the following services and programs that were developed and implemented with RPG funds have been sustained:

- Evidenced-based programs and services including Seeking Safety, the Matrix Model, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Motivational Interviewing
- Counselors are now addressing substance use and co-occurring mental health disorders

	• The intake process is streamlined, treatment providers are engaged in multi-disciplinary teams for families, and case management and advocacy for the children and whole family by the treatment provider will continue As the State of Oregon continues to develop and implement their Managed Care System and prepare for Health Care Reform, the NOCCS providers have served as a model for an integrated system of care for addictions and mental health, child welfare and the courts. Primary Care medical homes and Public Health Departments have emerged as new partners, working with the NOCCS programs to retain the level of integration and family focus for substance abuse treatment, co-occurring disorders and child well-being.
Project Director and Contact Information	Charlotte Dudley 1700 4th Street Baker City, OR 97814 (541) 519-3852 Ctdudley22@gmail.com
Project Evaluator and Contact Information	RMC Research 111 S.W. Columbia St. Suite 1200 Portland, OR 97201 (503) 223-8248 jknudsen@rmccorp.com

Name of Lead Agency	**Klamath Tribes**
Location	**Chiloquin, OR**
Title of Project	**Klamath Tribes**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Klamath County Congressional District 2
Brief Program Description	Under the guidance of the Children's Bureau, and the leadership of the Principal Investigator, Marvin Garcia (Director of the Social Services Program), the Klamath Tribes initiated a Regional Partnership Grant Project,

	including four partners; Klamath Tribes' Social Services Department, Klamath Tribes' Health and Family Services, Klamath Youth Development Center – a private nonprofit 501(c)(3) organization, and, the Williamson River Indian Mission – a private nonprofit 501(c)(3) faith-based organization. The overarching goal for the Tribes and the project partners was to reduce and ameliorate the corrosive effects of methamphetamine and substance abuse in the tribal community.
Target Population	The Program did not include target population data in the final report**.**
Participants Served	Children: 228 Adults: 205 Families: 210
Major Goals	**Major program goals included:** • Provide in-home family therapy throughout the service district in a structured, meaningful way that improves family functioning. • Provide Native American youth with culturally relevant opportunities for activities, education, and engagement. • Develop a foster-home network to serve the Tribes and Native Americans for respite or emergency needs. • Create a Narcotics Anonymous group to serve Native Americans and other support groups for teens or family members as needed. • Coordinate service delivery for substance abuse-affected children and families so that referred families get the fullest possible continuum of services. • Provide parenting education classes, child development classes for parents, and other training or education as needed and appropriate. • Undertake a statistically valid and well-designed evaluation of the project and activities. • Provide counseling and alcohol and drug (A&D) services to parents using methamphetamine or abusing other substances. • Provide ancillary services for families to provide assistance in securing counseling or other services needed to transition to stable, healthy family life. • Undertake outreach activities and hold an annual educational, community event to celebrate progress and educate the community at large of the problems associated with methamphetamine and substance abuse, as well as the resources available to combat them.

Key Major Program Services	**Case Management and In-Home Services** • Traditional Case Management • Intensive Case Management • Family Group Decision Making • Wraparound/Intensive In-home Services **Parenting/Family Strengthening** • Positive Indian Parenting Curriculum **Family Therapy Counseling** • Traditional/Short Term • Intensive/Long-Term **Mental Health and Trauma** • Mental Health Services • Trauma-Informed Services **Substance Abuse Treatment for Adults** • Non-Intensive Outpatient • Aftercare/Continuing Care • Family-Centered Substance Abuse Treatment/Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Therapy (CBT) • Motivational Interviewing (MI) **Substance Abuse Prevention Services** • Substance Abuse Prevention **Screening and Assessment** • Screening/Assessment for Substance Abuse Disorders • Psychological/Social • Family Functioning **Children's Services** • Remedial/Academic Supports • Mental Health Counseling • Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) **Cross-Systems Collaboration** • Clinical Program Training • Regular Joint Case Staffing

	• Cross-systems information/data Sharing
Partner Agencies and Organizations	**Substance Abuse** • State Substance Abuse Agency • Regional/County Substance Abuse Agency **Tribal** • Tribal Child Welfare Agency/Consortia Tribal Child Welfare • Tribal Substance Abuse Agency • Tribe/Tribal Consortium **Mental Health Services** • Mental Health Service Provider **Health Services** • Adult Health Services Provider • Children's Health Provider/Hospital **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Pre-experimental
Performance Indicators	The evaluation included both quantitative and qualitative outcomes. Quantitatively: • A greater percentage of Klamath RPG children (75.4 percent) were reunited with their families than children across all RPG Projects (70.1 percent), and across all RPG comparison groups (63.8 percent) • The majority of Klamath RPG children (84 percent) were in the custody of a parent/caregiver (i.e., in-home) at time enrollment in the Klamath RPG Program • Klamath RPG children overall had high rates of children staying at home through case closure (90.4%), but were no more likely to remain at home through program case closure than comparison children (88.7 percent), and less likely than Cross-site RPG group (93.5 percent) • North Carolina Children and Family Scale (NCFAS) findings indicate a significant shift away from mild, moderate, and serious problems in family functioning from pre to post-test.
Sustainability Status	RPG was not able to sustain any elements of the RPG Project beyond federal funding.

Project Director and Contact Information	Devin Collins Klamath Tribes 501 Chiloquin Blvd. Chiloquin, OR 97624 (503) 501-6921 deven.collins@klamathtribes.com
Project Evaluator and Contact Information	Frank Mondeaux, Research and Evaluation Consultant 5462 Bonita Rd. Lake Oswego, OR 97035 (503)332-0435 Fmondeaux@gmail.com

Name of Lead Agency	**OnTrack, Inc**
Location	**Medford, OR**
Title of Project	**OnTrack**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Jackson County Congressional District 2
Brief Program Description	In 2007, Jackson County formed a collaboration of partners committed to reducing foster care placements and making system changes which would result in a better experience for children and their families involved in the child welfare system. Partners included: Jackson County's Child Welfare Agency, OnTrack (the community's substance abuse treatment provider), the Community Family Court, The Family Nurturing Center and the Court-Appointed Special Advocates (CASA). Also in 2007, OnTrack applied for, and received, a 5-year RPG issued by the Federal Children's Bureau. OnTrack has succeeded in developing a model of care which can and will be spread throughout Oregon over time. As a result of these efforts, very few children of families involved in the project have been removed. Most of the children who were removed were returned very quickly and maintained strong relationships with their parents while out of the home. The services offered through the grant were broad and reached short- and long- term

	goals, including preserving families while parents undergo treatment, establishing sobriety, improving child-parent bonds and attachments, and helping families reshape their lives and move out of poverty with employment and housing assistance.
Target Population	**The project targeted:** Families that met the following criteria: • Children, aged eight and under, and their siblings who are involved in the child welfare system, who are currently in an out-of-home placement or who are at risk of entering an out-of-home placement as the result of a parent's substance abuse which has led to neglect.
Participants Served	Children: 292 Adults: 241 Families: 182
Major Goals	**Major program goals included:** • To enhance the well-being of children of meth abusing parents • To improve the outcomes of parents who are diagnosed with methamphetamine dependency • Families will have enhanced capacity to provide for their children's needs • Jackson and Josephine Counties will have new or increased ability to address parental methamphetamine abuse and its effect of children
Key Major Program Services	**Case Management and In-Home Services** • Intensive Case Management • Family Group Decision Making/Family Case Conferencing • Wraparound/Intensive In-Home Comprehensive Services **Parenting/Family Strengthening** • Evidence-Based Parenting or Family Strengthening Program - Nurturing Parenting **Engagement/Involvement of Fathers** • Targeted Outreach **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma-Informed Services • Trauma-Specific Services - Seeking Safety **Substance Abuse Treatment for Adults**

	• Residential/Inpatient Long-Term Treatment- Specialized for Parents w/Children • Intensive Outpatient and Partial Hospitalization - Matrix Model • Non-Intensive Outpatient • Aftercare/Continuing Care/Recovery Community Support Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies - Contingency Management • Recovery Coach/Specialist • Co-Location of Staff **Screening/Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Trauma • Other Specialized Child Screening and Assessment – Behavioral/Socio-Emotional, Family Functioning **Screening/Assessment – Substance Use and Other Adult Issues** • Other Specialized Adult Screening and Assessment – Mental Health/Co-Occurring Disorders, Trauma/Domestic Violence, Family Functioning **Children's Services** • Early Intervention • Mental Health Services for Children/Youth • Trauma Services for Children/Youth – Parent Child Interaction Therapy (PCIT) **Other Major Cultural Strategy** • Bilingual/Bicultural Home-Based Services **Family-Centered Substance Abuse Treatment**
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency • Regional/County Child Welfare **Substance Abuse** • Substance Abuse Treatment Agency/Providers **Courts** • Family Treatment Drug Court (FTDC) • Other Dependency Court • Court Appointed Special Advocate (CASA) **Criminal Justice, Law Enforcement, Legal and**

	Related Organizations • Attorney • Legal Services/Client Advocacy **Mental Health** • Mental Health Services Provider **Housing** • Housing/Homeless Services Provider **Education** • Early Childhood Services/Education Provider • Parenting Education/Services Provider **Employment** • State/ County Employment Agency • State/ County Temporary Assistance for Needy Families (TANF) or Welfare Office **Evaluator** • Evaluator (University-Affiliated or Other) **Other Community and Child/Family Services** • Home Visiting Agency/ Services Provider
Evaluation Design and Comparison Group Type	Quasi-experimental Historical, Aggregate
Performance Indicators	**Safety and Permanency** <u>Occurrence of Child Maltreatment</u>: Among members of the RPG treatment group that participated in a post-program follow-up period, only 10% of children experienced a substantiated maltreatment report subsequent to RPG entry. Thirty-three percent of comparison group children experienced a substantiated maltreatment report subsequent to reunification with their parent following the most recent removal due to maltreatment suggesting that children in the comparison group were roughly three times as likely to experience subsequent maltreatment as the RPG treatment group. <u>Reentries to Foster Care:</u> Among the RPG treatment group only 6% of children experienced a removal due to substantiated maltreatment subsequent to RPG entry. Twenty-eight percent of comparison group children experienced a removal due to substantiated maltreatment subsequent to reunification with their parent following the most recent

	removal due to maltreatment. This means that the comparison group children were four times as likely to experience a subsequent removal as the RPG treatment group. Timeliness of Reunification: Only 2% of children discharged from foster care to reentry spent more than 10 months in out-of-home placement. The average time to physical reunification was just over two months with the majority of children reunified with their parent within one month. Among the RPG treatment children, 98% were physically and legally reunified with their parent while only 51% of comparison children experienced legal reunification as their final family permanency outcome. Retention in Substance Abuse Treatment: At least 61% of families completed the program as of 9/30/12. The remaining 39% of families were still in the program at time of the Final Report.
Sustainability Status	From the outset of the RPG-funded project in 2007, the members of our Regional Partnership committed themselves to rigorous evaluation that would analyze process and outcomes and an equally rigorous cost analysis that would demonstrate return on community (or federal) investment. Armed with data, the Regional Partners were able to approach state legislators and to share with them a clinically proven, financially sound and trauma-informed transformational system for Child Protective Services. This led to the passing of SB 964 which will provide funding to sustain these successful efforts.
Project Director and Contact Information	Rita Sullivan, Executive Director OnTrack, Inc. 221 W. Main Street Medford, OR 97501 (541) 772-1777 ritaontrack@gmail.com
Project Evaluator and Contact Information	Marny Rivera, Evaluator OnTrack, Inc. 221 W. Main Street Medford, OR 97501 mschaef7@uaa.alaska.edu

Name of Lead Agency	**Children's Friend and Service**
Location	**Providence, RI**

Title of Project	Project Connect
Program Option	RPG 5-Year Grant (2007-2012); $500,000 annually
Geographic Area and Congressional District Served	Rhode Island Congressional Districts 1 & 2
Brief Program Description	Project Connect worked with high-risk families affected by problems of parental substance abuse and involved in the child welfare system. Project Connect served families in all of Rhode Island's 39 communities. Staff offered home-based counseling, nursing services and service linkage to services such as substance abuse treatment, safe and affordable housing and adequate health care for parents and their children. The program worked collaboratively with other providers, notably the Rhode Island Department of Children, Youth and Families (DCYF), to coordinate services for families and to advocate for improvements in service delivery. The program staff was co-located in each of DCYF's regional offices, facilitating referrals and increasing child welfare worker's access to expertise on substance abuse.
Target Population	**Project Connect worked with:** • High-risk families affected by problems of parental substance abuse and involved in the child welfare system
Participants Served	Children: 821 Adults: 589 Families: 390
Major Goals	**Major program goals included:** • Expanding statewide a proven, evidence-based comprehensive community-based program for substance-affected families involved in the child welfare system • Establishing a coordinated, system-wide response and training program for child welfare and community providers regarding children and families affected by a parent's use of methamphetamine and/or other substances • Increasing service coordination throughout Rhode Island between DCYF, substance abuse treatment providers, the medical community, the court and community-based agencies
Key Major Program	**Case Management and In-Home Services**

Services	• Intensive Case Management • Wraparound/Intensive In-Home Comprehensive Services **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma-Informed Services **Specialized Outreach, Engagement and Retention** • Co-location of Staff **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Specialized Child Screening and Assessment – Developmental **Screening/Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Specialized Screening and Assessment – Family Functioning
Partner Agencies and Organizations	**Child Welfare** • Department on Child, Youth and Families **Substance Abuse** • Institute for Addiction Recovery at the Rhode Island College and the Women in Recovery Task Force **Courts** • Family Treatment Drug Court (FTDC) **Tribal** • Criminal Justice, Law enforcement, Legal and Related Organizations **Mental Health** • Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Evaluation Design and Comparison Group Type	Quasi-experimental Same-time, Matched Population-Level
Performance Indicators	**Safety** <u>Recurrence of Maltreatment:</u> A total of 357 families were tracked over the five years to identify the extent to which families participating in the program were re-indicated for abuse or neglect. The six-month recurrence rate for Project Connect children was 2.1 percent. The national standard

	established by the Children's Bureau calls for a six-month rate no higher than 5.4 percent and in 2010, Rhode Island reported a six-month recurrence rate of 9.8 percent. **Permanency** Reunification: Among those children who were removed from the home after their initial contact with Project Connect, 77.0 percent were reunified with their parents. **Adult and Child Well-Being** Substance Exposed Newborn: Babies born to Project Connect parents were typically born substance-free; 91.0 percent of the children born while their parents were receiving services tested negative for illicit substances at their birth. Mental Health and Parenting: Seventy-six percent of the parents who were highly involved in services showed improvements in their mental health; 72.0 percent showed improvements in their parenting abilities. **Recovery** Completion of Substance Abuse Treatment: Sixty-three percent of the parents receiving substance abuse treatment successfully completed treatment. Parents who were highly involved in Project Connect services were the most likely to complete treatment.
Sustainability Status	The Project Connect contract for all the foundational services developed and provided over the past 20 years will continue via a direct contract with the state through DCYF. Services will continue to be billed directly to Medicaid. Children's Friend and Services has also committed to keeping the program services statewide and the staff members co-located in the DCYF regional offices. Children's Friend and Services was awarded a four-year demonstration grant through the National Abandoned Infants Assistance (AIA) Resource Center. The grant allows agency programs to work collaboratively on: 1) increasing protective factors; 2) strengthening families; and, 3) improving overall well-being for children of families affected by substance abuse, HIV/AIDs or other significant health issues.
Project Director and Contact Information	Valentina Laprade, Director Family Preservation 153 Summer St. Providence, RI 2903 (401) 276-4352 vlaprade@cfsri.org
Project	Lenore Olsen, Evaluator

Evaluator and Contact Information	Rhode Island College 610 Mt. Pleasant St. Providence, RI 02908 researchap@aol.com

Name of Lead Agency	**Aliviane, Inc**
Location	**El Paso, TX**
Title of Project	**Project Aware**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	El Paso County Congressional District 16
Brief Program Description	Aliviane, Inc. and the Texas Department of Family and Protective Services, Department of Child Protective Services (CPS) implemented Project Aware. Project Aware consisted of intensive case management services using the Assertive Community Treatment model. The program worked with families who had or were at risk of having, substance abuse issues, residing in El Paso County and who are under investigation by CPS and in danger of having their children placed outside the home. The program provided intensive case management to clients and engaged family members in the client's overall progress, worked with collaborating agency in a manner to benefit the client, and held periodic family activities to encourage and model a healthy and substance free manner for parents to interact with their children.
Target Population	**The project targeted:** • Families referred to the program by Child Protective Services (CPS), Family Based Safety Services Unit (FBSS) • At risk of having their children placed out of the home due to one or both parents or caregivers having substance abuse issues.
Participants Served	Children: 1,019 Adults: 480 Families: 403

Major Goals	**Major program goals included:** • improving the health and stability of families by facilitating access to treatment • engaging families in treatment, and acquiring the resources needed for rehabilitation and stable recovery • improving treatment outcomes for families by increasing coordination and communication in service delivery • improving long-term recovery for families by increasing family and social support systems
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management **Mental Health and Trauma Services for Adults** • Trauma-Informed Services **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing/Motivational Enhancement Therapy, Brief Intervention with Family Members • Targeted Outreach by Case Managers **Substance Abuse Prevention Services** • Information Dissemination and Education • Alternative Activities • Problem Identification and Referral **Screening/Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Other Specialized Child Screening and Assessment - Family Functioning **Screening/Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Other Specialized Adult Screening and Assessment – Family Functioning **Other Major Program Strategies** • Transportation • Educational Groups
Partner	**Child Welfare**

Agencies and Organizations	• Regional/County Child Welfare **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Providers **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Police/Sheriff Department • Drug Enforcement Agency (DEA) **Mental Health** • Regional/County **Department of Health and Human Services** • County Public Health **Housing** • State/County Housing Agency • Housing/Homeless Services Provider **Education** • Early Childhood Services/Education Provider • Parenting Education/Services Provider **Employment** • State/County Employment Agency • State/County Temporary Assistance for Needy Families or Welfare Office (TANF) **Evaluator** • Evaluator (University-Affiliated or Other) **Other** • Other Child/ family services provider • Church/Faith-Based • Domestic Violence Services • Peer/Parent/ Mentor Group
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level

Performance Indicators	The program did not include indicator data in the final report.
Sustainability Status	Due to budget cuts across the state of Texas and budgetary constraints in the community, Project Aware was unable to identify or obtain funding sources in order to continue the services. However, Aliviane was able to keep several of the project's staff and incorporated some of the program's components, including educational groups, case management, and transportation, into other departments.
Project Director and Contact Information	Carolina Gonzalez, Aliviane, Inc. 616 N. Virginia, Ste. F. El Paso, TX 79901 (915) 533-3132 cgonzalez@aliviane.org
Project Evaluator and Contact Information	Gustavo Martinez, Aliviane, Inc. 1901 Rio Grande El Paso, TX 79902 (915) 241-7272 grmmia@aol.com

Name of Lead Agency	**Houston Council on Alcoholism and Drug Abuse**
Location	**Houston, TX**
Title of Project	**Safe4Kids**
Program Option	RPG Grant (2007-2012); $500,000 annually
Geographic Area and Congressional District Served	Harris County Congressional District 7
Brief Program Description	Safe4Kids provided services to address the safety, permanency and well-being of children ages 0-4 involved with Child Protective Services (CPS) in Harris County, TX, and the neighboring regional counties of Liberty, Chambers and Montgomery. The Safe4Kids program worked with clients participating in Family-Based Safety Services (FBSS) through the Texas

	Department of Family and Protective Services (TDFPS) to reduce risk factors with the ultimate goal of parents maintaining custody of the children. Families involved with FBSS exhibited risk factors related to the safety of the children but the risks were not so severe as to warrant the immediate removal of the children from the home although some children were temporarily placed outside of the home, often in kinship care.
Target Population	**The Safe4Kids program targeted:** • Mothers participating in FBSS through the Texas DFPS and CPS, when child safety was deemed at risk due to maternal substance abuse and/or prenatal substance exposure • Children between zero and four years old
Participants Served	Children: 610 Adults: 295 Families: 292
Major Goals	**Major program goals included:** • Creating a coordinated, timely and effective system to serve parents and guardians involved with the child welfare system that have a substance abuse problem and their children • Helping parents or caregivers become sober or are in recovery from alcohol and drugs • Teaching parent and families the skills and knowledge required to better provide for their children • Improving the biopsychosocial well-being of children of people with substance abuse problems and/or children who were prenatally exposed to substances • Improving the likelihood that children involved with the child welfare system will be able to safely and permanently stay with their families
Key Major Program Services	**Case Management and In-Home Services** • Intensive Case Management • Wraparound/Intensive In-Home Services **Parenting/Family Strengthening** • Manualized/Evidence-Based Parenting Program – Nurturing Parenting **Mental Health and Trauma Services for Adults** • Mental Health Services • Trauma-Informed Services • Trauma-Specific Services – Seeking Safety

	Specialized Outreach, Engagement and Retention • Cognitive Behavioral Strategies – Motivational Interviewing • Co-located Staff **Screening and Assessment – Child Welfare and Other Children's Issues** • Specialized Child Screening and Assessment – Developmental, Behavioral/Socio-Emotional **Screening and Assessment – Substance Use and Other Adult Issues** • Specialized Adult Screening – Trauma Domestic Violence, Mental Health/Co-occurring Disorders, Parenting, Family Functioning **Children's Services** • Mental Health Counseling – Parent Child Interactive Therapy (PCIT)
Partner Agencies and Organizations	**Child Welfare** • Texas Department of Family and Protective Services – Child Protection Services Division **Evaluation** • DePelchin Children's Center **Substance Abuse** • The Council on Alcohol and Drugs Houston • Santa Maria Hostel, Inc.
Evaluation Design and Comparison Group Type	Quasi-experimental Same- time, Matched Population-Level
Performance Indicators	**Permanency** <u>Reunification:</u> A total of 210 children were placed in voluntary kinship placements at the start of Safe4Kids services. Of these, 118 children (56.2 percent) were returned home by the end of program services, 18 (8.6 percent) were transferred to State custody and 74 (35.2 percent) remained in voluntary kinship care. **Child Well-Being** <u>Child Development:</u> Using the Ages and Stages Questionnaire (ASQ), the site measured change from baseline to follow-up for 80 children. Cumulative results showed statistically significant improvements for four of the five sub-scales (skills) within the ASQ: 1) Communication; 2) Gross Motor; 3) Problem Solving; and, 4) Personal Social.

	Recovery Time to Treatment: A total of 92 mothers had sufficient data for both RPG program enrollment dates and treatment admission dates. The average number of days between Safe4Kids admission and start of treatment services was 29.81 days (SD=53.35). While this does seem to be a significant amount of time until start of services, many clients were resistant to residential treatment services. Clinicians worked with these clients first by providing in-home services. If the client was unsuccessful (e.g., relapse) the client would then be enrolled in residential treatment. Retention in Substance Abuse Treatment: A total of 51 out of the 60 clients (85.0 percent) referred for residential substance abuse treatment remained in treatment throughout completion. The average length of stay for residential treatment for those completing the program was 77.41 days (SD=62.15).
Sustainability Status	**The following key program components were supported beyond grant funding:** • A continued process for communicating and exchanging information with referral sources (the partners discovered that case staffing which included the client and a representative from each of the partner agencies greatly improved communication, care coordination and client participation) • Referrals for client services in regards to treatment, counseling, parenting and substance abuse education
Project Director and Contact Information	Leonard Kincaid, Program Director The Council on Alcohol & Drugs Houston Safe4Kids Program P.O. Box 2768 Houston, TX 77252-2768, or 303 Jackson Hill Street Houston, TX 77007 (280) 200-9331 lkincaid@council-houston.org
Project Evaluator and Contact Information	Jason Lau, Senior Evaluator 4950 Memorial Dr. Houston, TX 77007 (713) 802-7797 jlau@depelchin.org

Name of Lead Agency	**Lund Family Center**
Location	**Burlington, VT**
Title of Project	**Regional Interagency Screening, Assessment, and Treatment Collaboration**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Chittenden County Congressional District 1
Brief Program Description	Lund Family Center, a comprehensive residential and community treatment program for substance abusing women and their children located in Burlington (Chittenden County), Vermont developed a regional partnership to improve well-being and permanency outcomes for Vermont children affected by substance abuse." Lund partnered with Vermont's child welfare agency (Department of Children and Families Division of Family Services) and Department of Health Division of Alcohol and Drug Abuse Programs. Lund has built on existing services to greatly enhance collaboration with the child welfare and substance abuse agencies to increase the well-being of children and improve permanency outcomes.
Target Population	**The project targeted:** Families that met the following criteria: • Families whose children who are in, or at-risk, for an out-of-home placement due to methamphetamine or other substance abuse by a parent/caretaker living in Chittenden County
Participants Served	Children: 1,180 Adults: 654 Families: 565
Major Goals	**Major program goals included:** • Safety: Protect children from abuse and neglect • Permanency: Increase permanency and stability for children in their living situations • Well-Being: Enhance the capacity of families to provide for their children's needs

	• Service Capacity: Increase the community's ability to address parental/caretaker substance abuse and its effect on children
Key Major Program Services	**Case Management and In-Home Services** • Traditional Case Management • Intensive Case Management • Family Group Decision Making • Wraparound/Intensive In-Home Services **Visitation Services** • Supportive Supervised Visitation **Family Therapy/Counseling** **Engagement/Involvement of Fathers** • Targeted Outreach **Mental Health and Trauma Services for Adults** • Psychiatric Care • Trauma Informed Services • Trauma-Specific Services - Seeking Safety, Beyond Trauma, A Woman's Way through Twelve Steps **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies – Motivational Interviewing/Motivational Enhancement Therapy • Co-location of Staff • Recovery Coach/Specialist **Family-Centered Substance Abuse Treatment/Services** **Screening and Assessment – Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Specialized Screening and Assessment – Developmental, Prenatal Exposure/Risk, Behavioral/Socio-Emotional **Screening and Assessment – Substance Use and Other Adult Issues** • Screening and Assessment for Substance Use Disorders • Specialized Screening and Assessment – Mental Health/Co-Occurring Disorders, Parenting, Health/Medical
Partner Agencies and Organizations	**Child Welfare** • State Child Welfare Agency

	Substance Abuse • State Substance Abuse Agency • Substance Abuse Treatment Agency/Provider **Courts** • Family Treatment Drug Court (FTDC) **Criminal Justice/ Law Enforcement/ Legal/Related** • State Corrections **Health Services** • County Public Health **Other Evaluation and Training** • Evaluator (University-Affiliated or Other)
Evaluation Design and Comparison Group Type	Quasi-experimental Same-Time, Matched Population-Level
Performance Indicators	**Safety** <u>Colocation Component:</u> Recurrence of Maltreatment – Clients in the Colocation component had a lower incidence of recurrence of maltreatment than those in the comparison group. 13.5% of treatment and 23.5% of control children had a new reported occurrence or reoccurrence of maltreatment during the two-year period following the date the case was opened as an RPG case. <u>Assessment Bed – Recurrence of Maltreatment:</u> Clients in the assessment bed treatment group had a lower incidence of reoccurrence of maltreatment than those in the comparison group. 3.4% of the treatment group had an occurrence or reoccurrence in the first six months compared to 6.2% for the comparison group. **Recovery** <u>Access to Treatment:</u> Clients in the Colocation Component had a mean time from RPG file open to initial SA assessment of 8.4 days. Mean time from the initial SA assessment to treatment admission was 27.8 days. **Well-Being** <u>Coordinated case management:</u> While almost all treatment group members (co-location) receive joint case management services and cross agency assessment conferences, differences in families receiving a cross-agency assessment conference every 90 days was significant 93.6% for the treatment group and 0.6% for the control group.

Sustainability Status	The Vermont Commissioner of DCF is trying to replicate the model in other regions of the state by creating three private-public partnership pilot projects using the local parent-child centers and DCF in other regions of Vermont. The Vermont RPG's project components, specifically the assessment beds, the co-location of treatment staff within child welfare, and the children's play lab have been incorporated into existing programs at varying degrees of success.
Project Director and Contact Information	Kimberly-Ann Coe P.O. Box 4009 Burlington, VT 5401 kimc@lundfamilycenter.org
Project Evaluator and Contact Information	Charles Mindel Mindel Evaluation Services 98 High Meadow Lane Middlesex, VT 5602 chmindel@gmail.com

Name of Lead Agency	**Wisconsin Department of Health and Family Services**
Location	**Madison, WI**
Title of Project	**Wisconsin Department of Children and Families**
Program Option	RPG 5-Year Grant; $500,000 annually
Geographic Area and Congressional District Served	Dane County Congressional District Statewide
Brief Program Description	The Western Wisconsin Collaborative for Children's Safety and Permanency was an alliance of state, regional, and county/tribe-level partners who committed to responding effectively to the safety and permanency needs of children whose parents or caregivers abuse alcohol, methamphetamine, or other drugs. The Collaborative proposed a Region-wide systems-transformation initiative that focused its efforts on:

	• Building providers' capacity for family-centered interagency coordination of services • Eliminating barriers to service access, engagement, retention, and recovery. The project was a state led effort, involving 18 counties and two tribes, with the goal of building interagency collaboration through the development or enhancement of Community Services Teams (CSTs). Funding was allocated across the sites to purchase services to address a family's needs as identified by the CSTs. State leaders also proposed a state-level data matching project for families involved in both the child welfare and substance abuse treatment systems.
Target Population	**The project targeted:** The children and their families who are in, or at risk of out-of-home placement as a result of parents' or caretakers' methamphetamine or other substance abuse and living in one of the 18 Counties and two tribes in the Western Wisconsin Region. At the time of the RPG application, Wisconsin's Western Region was the area of the State with the highest concentration of methamphetamine abuse.
Participants Served	Children: 804 Adults: 903 Families: 565
Major Goals	**Major program goals included:** • Service Capacity: Increase the Region's capacity to respond in collaborative, coordinated ways to parents'/caregivers' SUDs and their effects on children's lives and safety • Family Support: Promote family safety, stability, and capacity to meet children's needs through collaborative, family-centered case planning, case management and support. • Parents'/Caregivers' Recovery: Promote parents /caregivers' retention in appropriate treatment, ongoing recovery from substance use disorders, and responsible life choices. • Children's Safety: Protect children of parents/caregivers identified with SUDs from abuse and neglect. • Permanency: Promote permanency and stability in these children's living situations.
Key Major Program Services	**Case Management and In-Home Services** • Intensive/Coordinated Case Management • Wraparound/Intensive In-Home Comprehensive Services

	Mental Health and Trauma Services for Adults • Trauma Informed Services-Seeking Safety **Specialized Outreach, Engagement and Retention** • Cognitive Behavioral Strategies- Motivational Interviewing **Substance Abuse Prevention Services** • Environmental Approaches **Screening and Assessment-Child Welfare and Other Children's Issues** • Screening and Assessment for Child Welfare Issues • Screening and Assessment for Child Trauma • Other Specialized Child Screening and Assessment-Substance Use, Mental Health/Psychological, Behavioral/Socio-Emotional **Children's Services** • Early Intervention and Developmental Services **Cross-Systems Collaboration** • Clinical and Program Training • Cross-systems policies and procedures • Regular Joint Case Staffing Meetings • Cross-systems Information Sharing and Data Analysis • Partner Meetings
Partner Agencies and Organizations	**Child Welfare** • Regional/County Child Welfare Agency **Substance Abuse** • Regional/County Substance Abuse Agency • Substance Abuse Treatment Agency/Provider(s) **Courts** • Family Treatment Drug Court **Criminal Justice, Law Enforcement, Legal and Related Organizations** • Local Law Enforcement (police, sheriff) • Drug Endangered Children (DEC) **Mental Health** **Health Services** • Regional/County Mental Health Agency

	• Mental Health Services Providers **Education** • Individual Schools **Employment** • Employment Services Provider **Other Community and Child and Family Services** • Domestic Violence Services Providers/Agency
Evaluation Design and Comparison Group Type	Pre-experimental No comparison group The inability to access adult treatment data and inconsistent and incomplete child welfare data significantly limited the evaluator's ability to complete the evaluation and demonstrate impact on selected outcomes.
Performance Indicators	The grantee selected the following Performance Indicators. However, they were unable to consistently collect data and report child welfare outcomes in approximately 1/3 of their sites and unable to match adult treatment data, thus no Recovery outcomes were reported throughout the grant. **Safety** Occurrence of child maltreatment **Permanency** Children remain at home Re-entries to foster care Timeliness of reunification **Recovery** Access to treatment Retention in substance abuse treatment **Well-Being** Parenting: Percentage of parents or caregivers who demonstrate increased parental capacity to provide for their children's needs and family's well-being
Sustainability Status	The overall program model of Community Services Teams (CSTs) will be sustained without grant funding. Of the original 18 counties and two tribes there were 12 sites with functioning CSTs, though they ranged from highly functional CSTs to those that were still in the early stages of development. The two tribes merged with their neighboring counties to form joint CSTs. The remaining counties were not able to develop the partnerships needed,

	lacked the staffing necessary to facilitate the team or had only sporadic involvement from community partners. The funding sources used to support the project varied by county and tribe. All counties were encouraged to have multiple funding sources to support their CSTs. Some of the sources used are Promoting Safe and Stable Families (PSSF), Mental Health Block grant, General Purpose Revenue, County Tax Levy, private and public grants, and Substance Abuse Block grant. Though a formal cost analysis was not conducted, the stronger teams were able to demonstrate cost savings and report those findings to local and state decision makers. A critical component of the sustainability planning included an expectation of the more highly functional teams to mentor new and developing teams in all program operations, including program sustainability.
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